Assessing the mental health of Afghan refugee childrenin Peshawar schools

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MSc by research

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2004

Abstract

Children who are forcibly uprooted from their homes experience enormous losses, increased exposure to violent conflict, and severe deprivation. Much research remains to be done concerning the impact of displacement related adversity on the mental health of children and adolescents. A psychometric screening tool, the Strengths and Difficulties Questionnaire (SDQ), supplemented with anthropologically-informed research methods, was employed to appraise the mental health of 128 Afghan boys and girls, aged 11 to 16, attending four schools in Peshawar, Pakistan. Equal numbers of children were born in Afghanistan and Pakistan, and one third had no father living at home. Parents, teachers and children provided questionnaire data on mental health difficulties and prosocial behaviour, and children's projective drawings and open-ended interviews provided contextual information about life and future expectations in Peshawar. Informants were discrepant in their mental health ratings: 22% of sample children were 'probable' cases for a psychiatric disorder based on combined parent and teacher information, compared to just 5% based solely on information provided by parents. All children had normal prosocial abilities. Contrary to expectation, a purposive sample of children orphaned from one or more close relatives did not differentiate themselves in terms of mental health. Age and gender had no detectable impact on mental health ratings. Children whose fathers were not at home were 6 times more likely to receive abnormal mental health scores from both their parents and teachers ($p<0.002$). Children themselves reported more difficulties if they had large extended families ($p=0.027$). Children born in Afghanistan and Peshawar did not differ in their mental health. However, children who

had lived longest in Peshawar had more difficulties according to their parents than those who had relocated most recently (p=0.006). Gender differences showed up in employment (30 boys worked compared to 3 girls) and school attainment (girls were 3 times more likely to get the best marks). Poor scholastic achievement had a significant association with mental health problems (p=0.025). Qualitative data showed that Afghan children experienced substantial hardship in Peshawar but that they maintained strong family ties, religious values, and Afghan identity. Boys and girls reported very high aspirations and had positive outlooks for the future. Educational and professional success was seen as a means to helping family members and fellow countrymen, and participating in the rebuilding of Afghanistan. These data provide evidence for both childhood vulnerability and resilience to displacement adversity, and advocate the use multiple informants and a multidisciplinary approach for studying the mental health of refugee children.

Contents

Chapter 1

Introduction

a. Issue: the mental health of refugee children

The impact of forced displacement on the mental health of children is an issue of global importance. Throughout history people have had to abandon their homes and seek safety elsewhere to escape persecution, armed conflict or political violence (UNHCR[1] 2000). Children under the age of eighteen account for over half the 30 to 35 million people currently uprooted from their homes worldwide (UNICEF[2] 2004), including an estimated 10 million refugees and 20-25 million internally displaced persons (UNHCR 2003). Research into the consequences of violent conflict and displacement has focused on physical health, but there is growing concern for the psychosocial and mental health outcomes of those displaced (WHO[3] 1996). While considerable literature exists concerning adult refugees, less has been published describing the experiences of refugee children, how they understand and mediate these events, and how they are affected by them (Ahearn & Athey 1991).

The experiences of children and families forced to flee are diverse and multiple, often including trauma, loss and severe deprivation before, during and after displacement (Athey & Ahearn 1991), as illustrated in the following passages:

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[1] Office of the United Nations High Commissioner for Refugees
[2] United Nations Children's Fund
[3] World Health Organisation

Graça Machel, appointed by the UN Secretary-General to assess the impact of armed conflict on children, has described some of the dangers children are exposed to when they are forced to flee their homes in 'The Impact of War on Children' (2001:26-27): "Families abandon their homes in fear of death or torture. They leave behind property, relatives, friends, familiar surroundings and established social networks. Their anguish and sense of loss can be overwhelming. Though the decision to leave is usually made by adults, even the youngest children can sense their parents' fear and uncertainty. Escape itself is fraught with peril. Families risk everything from ambush and shelling to snipers and landmines, often walking for days with limited quantities of water and food. Under such circumstances, children become acutely undernourished and prone to illness. Girls in flight are at special risk of sexual abuse. And both boys and girls may be seized and forcibly recruited into armed groups."

Nils Kastberg, Director of the Office of Emergency Programmes, UNICEF, has also outlined some of the experiences of displaced children in 'Strengthening the response to displaced children' (2002:4): "Today, an estimated 20 million children are displaced by armed conflict or human rights violations. Forced to flee their homes, often travelling great distances to escape enemy fire, these children are the most frequent victims of violence, disease, malnutrition and death. In the chaos of flight, these boys and girls may become separated from their parents and families and thus exposed to far greater dangers. Adolescents have special needs because they are especially vulnerable to forced recruitment, abduction, trafficking or exploitation, and for girls sexual violence and rape

are risks. In many cases, 'temporary' displacement often extends well over a decade. In such cases, children may spend their entire childhood in camps."

b. Context: Afghan refugees in Pakistan

Afghanistan is unique in terms of magnitude of population displacement and resettlement (Figure 1.1). Iran and Pakistan host an estimated 2.5 million refugees, and a further 2 million are thought to have returned to Afghanistan in 2002 (UNHCR 2003). Since the terror attacks of September 11th 2001, the plight of Afghan refugees has been thrust into the international spotlight (Wright 2002), but Afghanistan has been experiencing a refugee crisis of unimaginable scale for more than two decades (Table 1.1 for an overview). Although figures of refugee movements vary hugely, an estimated one in four Afghans has been a refugee between the Soviet invasion of Afghanistan in 1979 and the present day (Ruiz 2002:8).

Figure 1.1. Afghan refugees in neighbouring countries (UNHCR 2001)

Table 1.1. Chronology of Afghan refugee crisis (1973-2002)

1973	After more than two centuries of monarchy, King Zahir Shah is ousted in a military takeover by Mohammed Daoud.
1978	President Daoud killed in coup. Nur Mohammed Taraki declared president of revolutionary council.
1979	Islamic opposition (*mujaheddin*) protest government's communist policies. Refugee exodus begins. President Taraki killed in palace coup in September and succeeded by Hafizullah Amin. Soviet troops enter Afghanistan in December. Amin is executed and Babrak Karmal proclaimed President. 600,000 refugees by end of year.
1980	600,000 refugees UN calls for immediate withdrawal of foreign forces. *Mujaheddin* armed resistance increases.
1983	3.9 million refugees War spreads and intensifies as arms flow to rebels increases.
1987	5.1 million refugees Babrak Karmal replaced by chief of secret police, Mohammed Najibullah.
1988	5.9 million refugees Geneva Accords call for withdrawal of Soviet troops. While some refugees continue to flee others begin returning.
1989	6.1 million refugees Last Soviet soldier departs on 25 February.
1990	6.2 million refugees A peak of 6.2 million refugees is reached, but 350,000 have returned since 1988.
1992	6.0 million refugees Najibullah government falls to *mujaheddin* in April. Sibghatullah Mojadidi named president and later replaced by Burhanuddin Rabbani. 1.6 million refugees go home.
1993-1994	4.4 million refugees Kabul reduced to rubble in factional fighting. Up to one million displaced inside Afghanistan. Another 1.3 million refugees return home to peaceful areas.
1994	3.4 million refugees Taliban guerrilla forces capture southern city of Kandahar.
1995	2.7 million refugees Taliban capture Herat and advance to outskirts of Kabul. Repatriation from Iran stops after fall of Herat.
1996	2.7 million refugees Taliban capture Jalalabad and Kabul in September. Najibullah hanged after sheltering in UN compound since 1992. Fighting in western and central Afghanistan.
1997	2.7 million refugees Fighting continues in western, central and northern Afghanistan. Taliban briefly capture northern city of Mazar-i-Sharif, but are driven out after 4 days. Repatriation continues to eastern and southern areas.
1999	2.7 million refugees Civil war boosts number of IDPs to more than 500,000, but 250,000 civilians return to peaceful areas.
2000	2.7 million refugees Worst drought in living memory affects millions as civil war continues, though nearly 300,000 exiles return home.

2001	3.6 million refugees War and drought spark new exodus early in the year. Displacement surges beyond a million following the September terrorist attacks as people leave cities and towns fearing reprisals. Despite UN pleas, Afghanistan's neighbours close their borders, but up to 200,000 people still cross into Pakistan while others are stuck in makeshift IDP camps in border zones. UNHCR establishes the first of 15 new refugee camps in the country's border belt. With the fall of the Taliban in late November, refugees and displaced persons begin making their way home. Early December sees an agreement among Afghan groups meeting near Bonn to establish a six-month interim authority to rule the country, headed by Hamid Karzai.
2002	3.7 million refugees Spontaneous returns gather pace, but some Afghans continue to flee the persistent drought. Others speak of persecution and fear due to ethnic attacks in some parts of northern Afghanistan in the weeks following the fall of the Taliban. The authorities investigate the reports and act to quash the random violence. In March, UNHCR and the interim authority start facilitating returns, expecting some 1.2 million refugees and IDPs to return home, but the number of refugees repatriating under the initiative rapidly exceeds expectations. A Loya Jirga (grand council of hundreds of Afghans) meeting in Kabul in June declares Karzai President of a Transitional Authority expected to hold office for two years. By mid-year, more than 1.2 million refugees take up the UN aid package and go home, while another 400,000 IDPs return, half with UN help. UNHCR ups its planning figure for 2002 to more than 2 million returnees.

Adapted from UNHCR (2004a) website: http://www.unhcr.ch/cgi-bin/texis/vtx/afghan?page=chrono

i. Historical and political context of Afghan refugee crisis

Soviet troops invaded Afghanistan in December 1979, setting in motion a major exodus of refugees to neighbouring countries. Flight was seen not only as a means of escaping conflict but also as a religious act responding to invasion by a non-Islamic power (Centlivres & Centlivres-Demont 1988, Shahrani 1995). By the early 1990s over 3 million refugees had fled to Pakistan, and a further 3 million had taken refuge in Iran (Marsden 1999:56). Most of the Afghan refugees in Pakistan were accommodated in UNHCR-funded camps in Pakistan's two western-most provinces, the North West Frontier Province (NWFP) and Baluchistan (Ruiz 2002:8). Over the years, the refugees built their own mud houses and the camps gradually evolved into 'refugee villages'. Although originating mainly from rural areas, the refugees were not given their own land to cultivate but were allowed to move freely around the country in search of work

(Turton & Marsden 2002:17). Some maintained a foothold in both countries, by living in Pakistan, while hiring tenant farmers to work their land in Afghanistan (Ruiz 2002:9).

The withdrawal of Soviet troops from Afghanistan in 1989, followed three years later by the overthrowing of the People's Democratic Government of Afghanistan (PDPA) by the *mujaheddin* ('fighters in the *jehad*, or Holy War') in 1992 prompted massive repatriation of refugees to Afghanistan. During that year, more than 900,000 individuals crossed the border from Pakistan to Afghanistan (UNHCR 1994, cited in Turton & Marsden 2002:18). However, lack of funding for reconstruction and repatriation from the west, as well as fighting between the various *mujaheddin* factions, meant that repatriation in the following years continued at a much-reduced level. Beginning with the takeover of Kandahar in 1994, the rise of the Taliban was increasingly met with resistance from many of the former *mujaheddin* groups which eventually joined together to form the Northern Alliance (Ruiz 2002:9), and Afghans continued to be displaced throughout the 1990s (Turton & Marsden 2002:19).

Shahrani (1995) and Centlivres and Centlivres-Demont (1988) have drawn attention to the importance of the self-definition of Afghan refugees as *muhajarin* ('those who leave their homes in the cause of Allah, after suffering oppression') and their shared values with their Pathan (Anglo-Indian name for Pakistani Pashtuns) hosts in NWFP. At least in the early years of their exile, they were warmly welcomed as beneficiaries of traditional hospitality, as dictated by the strict code of honour, (*pushtunwali*) practised by Pashtuns (Ahmed 1986, cited in Centlivres & Centlivres-Demont 1988:144). Here they

maintained a tradition of reliance on tightly organised local kin-based village and tribal communities led by respected elders (Shahrani 1995:196).

The UNHCR and WFP[4], faced with huge funding shortfalls for their relief activities for Afghan refugees in Pakistan, as well as robbery and threats from local warlords, ended food aid to most refugees living in the camps in late 1995 on the basis that they had sufficient access to income-earning opportunities to overcome dependence on rations. Refugees living in camps were now also required to make financial contributions towards education, health and water supply services (Marsden 1999:58). The decision to end food aid was to have a significant long-term impact both on refugees in Pakistan and the government of Pakistan's attitude towards their presence. Tens (maybe hundreds) of thousands of refugees moved to Pakistan's cities where authorities blamed them for the growing social and economic ills of the country (Ruiz 2002:9-10).

Towards the end of the 1990s, the continuing influx of large numbers of Afghans due to conflict and severe drought, along with the abandonment of the region by the international community, led to the continued hardening of the Pakistani government's attitude and increased harassment towards the Afghan *muhajarin* who were increasingly seen as economic migrants rather than fleeing oppression (Turton & Marsden 2002:20). In response to yet another influx of refugees caused by further fighting and drought in Afghanistan, Pakistan officially closed its border with Afghanistan in November 2000 (Ruiz 2002:10).

[4] World Food Programme

The US-led military action in Afghanistan in October 2001 led to the mass displacement of hundreds of thousands more civilians. Frustrated by years of responsibility for Afghan refugees, and with very limited international burden sharing for their care, Pakistan kept its border with Afghanistan officially closed in the wake of September 11. Nonetheless, some 200,000 new refugees entered Pakistan while others were stuck in makeshift camps along the border (UNHCR 2004a). 3.5 million Afghan refugees were estimated to be living in Pakistan prior to the mass repatriation that began in early 2002 (UNHCR 2002, cited in Turton & Marsden 2002:24) after the fall of the Taliban regime and establishment of the Afghanistan Interim Authority (AIA) in December 2001. The UNHCR voluntary repatriation programme has helped in the region of 2 million Afghans to leave Pakistan since it began its programme in 2002, the largest and swiftest population return in modern history, and a further 400,000 Afghans are expected to return from Pakistan this year (UNHCR 2004b).

ii. War experiences of Afghan children and life in the refugee camps

Afghan children have grown up during a turbulent period in history characterised by intense political turmoil and fighting, during which they have been exposed to diverse and multiple traumatic stressors including fear of violence, physical injury such as amputation resulting from landmines, poor health, family separation and bereavement of family members, destruction of houses, villages and land, interrupted education, political repression, extreme poverty and social marginalisation. One in four Afghans is expected to die before their fifth birthday (UNICEF 2003:20). According to Wali Wardak

(1993:350), "Many of them [Afghans] have been through the experience of a prolonged journey through mountains and very rough terrain. On this journey, they experienced fatigue, changes in diet and climate... with the constant fear of being caught, killed, or imprisoned". Others have spent their entire lives in ghettoised camps or more permanent refugee villages in Pakistan where they have been able to exert very little influence over their current or future situations (Wardak 1992:154).

Michael Jonathan Grinfeld has described the living conditions in a refugee settlement near Peshawar (*Psychiatric Times*, April 2002): "Once a tent city, Akora Khattak's row-upon-row of mud huts at times has housed as many as 250,000 people, although its current population is estimated at 15,000 families comprising 110,000 refugees. Deep gullies run between the ramshackle dirt houses carrying away sewage in the open. Wells supply the only water, and food is in short supply. Many children eat only once every 24 hours. Sparse resources mean medical care is often unavailable, and mental health care is, for the most part, nonexistent... Cultural and religious norms also have their affects. Many of the women lost their husbands during the conflicts or live with men who are too disabled to work. They are prohibited from venturing out alone to take jobs, and only their children can assume the burden of being family breadwinners. Usually employed at physically demanding manufacturing or assembly jobs, or subject to the vagaries of street vending, these children are commonly the targets of physical and sexual abuse. Thousands of children in the camps receive little or no education."

c. Approaches to child mental health

People have known for a long time that war can have a negative effect on emotional, mental, spiritual, and social well-being. Debates about how children are affected by adversity have tended to reflect historical and cultural notions of childhood (Boyden 2003, Boyden & Mann 2000, Panter-Brick 2000, Sheper-Hughes 1989, Woodhead et al 2003) and dominant ideas about mental health and well-being (Boyden 2003, Boyden & Mann 2000, Eyber 2002). For example, prior to the development of biomedicine and psychological theories and knowledge in the west, the suffering, distress, and illness caused by armed conflict had been considered primarily spiritual, religious or political affairs rather than medical or psychological issues (Summerfield 2000). Theoretical and practical approaches to child mental health continue to be constantly evaluated and contested. The remainder of this section outlines two such approaches to research and assistance to war-affected and displaced children: i) a western biomedical intervention model focusing on the impact of war trauma on individual child mental health; and ii) a psychosocial approach prioritising children's own understandings of their well-being in the context within which events are experienced and managed. This section ends with a summary of the major differences between the two approaches (Table 1.2), and examples of studies that have integrated biomedical and psychosocial research methods.

i. Western biomedical approach

There are two dominant classification systems of mental disorders employed by western psychologists and psychiatrists. The World Health Organisation (WHO 1992:5) International Classification of Diseases (ICD-10) defines a mental disorder as "a

clinically recognisable set of symptoms or behaviour associated in most cases with considerable distress and substantial interference with personal functions." In agreement with this, the American Psychiatric Association (APA 1994:xxi) Diagnostic Statistical Manual (DSM-IV) defines a mental disorder as "a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (a painful symptom) or disability (impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain or an important loss of freedom."

Numerous diagnostic and screening instruments for different mental health problems exist and studies estimating prevalence rates of mental health disorders have employed varying methodologies and diagnostic criteria (Bird 1996, Thabet et al 2000, Thabet & Vostanis 1999). The Strengths and Difficulties Questionnaire (SDQ) selected for this study was developed in England by Prof. Robert Goodman in the 1990s (Goodman 1994, 1997, 1999). It is a simple behavioural screening questionnaire based on WHO (1994) and APA (1994) nosological concepts for use in clinic and community settings[5]. The SDQ takes about five minutes for a parent, teacher or child to complete (forms are reproduced in Appendix 1.1 and are available free of charge on http://www.sdqinfo.com) and triangulation between informants is recommended (Goodman et al 2000a). The SDQ

[5] The reliability and validity of the informant-rated SDQ has been shown to compare favourably to other behavioural screening questionnaires including the parent and teacher Rutter questionnaires (Goodman 1997) from which the SDQ was originally developed (Goodman 1994), and the much lengthier Child Behaviour Checklist (CBCL) (Goodman & Scott 1999) developed by Achenbach; and the validity of the self-report SDQ has been demonstrated through its ability to discriminate between community and clinic samples (Goodman et al 1998).

provides balanced coverage of three common groups of disorder: emotional such as anxiety, depression and obsessions; conduct disorders characterised by awkward, troublesome, aggressive and anti-social behaviours; and hyperactivity involving inattention and over-activity (Goodman 1997).

ICD-10 (WHO 1994) and DSM-IV (APA 1994) diagnostic criteria for most child psychiatric disorders include both *symptoms* and *impact*, in terms of substantial distress or social incapacity. Several studies have shown that symptoms alone are not a good guide to the presence or absence of psychiatric disorders in childhood. Studies of mental health that have defined psychiatric disorders solely in terms of symptoms and not considering resultant distress or social incapacity have resulted in implausibly high rates of caseness (Bird et al 1988 & 1990, Simonoff et al 1997). This in turn can mislead service planners by labelling many children with relatively harmless symptoms as having psychiatric disorders (Meltzer et al 2003). The extended version of the Strengths and Difficulties Questionnaire (SDQ), employed in this study, includes a measure of impact on home life, friendships, classroom learning and leisure activities (Goodman 1999). These four domains are the main areas that need to be considered when rating psychosocial disability using the WHO's classification of child and adolescent psychiatric disorders (WHO 1996, cited in Goodman 1999).

Despite the assertion that mental health is not simply the absence of detectable mental disease but "a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able

to make a contribution to his or her community" (WHO 2001:1), there has been a tendency to focus on mental illness or disease rather than the positive promotion of mental health. Whereas traditional child psychiatric screening questionnaires have focused on mental health problems, the SDQ also includes a measure of prosocial strengths and competencies in order to give a more balanced view of mental health (Goodman 1997). The inclusion of strengths as well as difficulties has also been shown to increase acceptability of the questionnaires to informants and make them more suitable for use in the general population where the majority of children are healthy (Goodman & Scott 1999).

The SDQ has been validated in several cross-cultural contexts. Surveys often use translated versions of western questionnaires but it is uncertain how far linguistic equivalence can be achieved simply through the process of translation and back-translation. Thabet et al (2000) aimed to identify mental health profiles in different age bands in an Arab sample in Gaza using the SDQ. According to factor analysis and reliability analysis, the SDQ was considered very promising as a screening and rating scale in a non-western population. However, there were differences for instance in parents' perceptions of emotional problems in younger children, indicating that not all western diagnostic categories were directly applicable to the Arab population. The SDQ was also applied to patients from two culturally distinct populations attending mental health clinics in Britain and Bangladesh (Goodman et al 2000a). The level of agreement between SDQ prediction and an independent clinical diagnosis was substantial and highly significant in both samples despite differences in language, culture and socio-economic

contexts. In a subsequent study, SDQ scores were also shown to satisfactorily distinguish between community and clinic samples in Bangladesh (Mullick & Goodman 2001). The self-report Arabic version of the SDQ has also recently been shown to discriminate well between school children and children attending a mental health clinic in Yemen (Almaqrami & Shuwail 2004).

Many debates about the validity of western diagnostic constructs and research tools for the diagnosis of mental health cross-culturally have focused on Post Traumatic Stress Disorder (PTSD), first identified as a syndrome in American veterans of the Vietnam War by the American Psychiatric Association in 1980 (DSM-III). Two studies have examined the prevalence of PTSD and other psychiatric disorders among a sample of 38 Afghans aged 12 to 24 living in the United States[6] (Mghir et al 1995, Mghir & Raskin 1999). The earlier of these studies reported that 5 individuals met criteria for PTSD, 11 individuals met criteria for major depression, and 13 individuals had either PTSD or major depression or both. There was a significant positive correlation between psychiatric diagnosis and the number of traumatic events experienced. The latter study focussed on the differential effects of war trauma and subsequent refugee status on two ethnic subgroups. A group with Tajik parents showed significantly less evidence of PTSD and depression than another group with Pashtun parents.

[6] As described in Mghir et al (1995), the instruments employed were: 1) The Harvard Trauma Questionnaire (HTQ; Mollica et al 1992), 2) The Structured Clinical Interview for DSM-III-R (SCID; Spitzer et al 1988), 3) The Clinician-Administered PTSD Scale (CAPS; Blake et al 1990), and 4) The Beck Depression Inventory (BDI; Beck et al 1961).

Critics of this approach maintain that by focusing on individual trauma, it disallows the context and culturally constructed 'meaning' of suffering for the individual person or family. According to Derek Summerfield (2000), western biomedical concepts of trauma that focus on the individual are inappropriate for the study of war and mental health because war is not a private experience, and the suffering it causes is experienced in social context. Unfortunately, there is very little information available regarding the range of responses to war-trauma, ways in which it is interpreted cross-culturally by individuals within their local context, and which methods work best to uncover the nature of psychopathology in non-western settings (Ahearn 2000).

ii. Psychosocial approach

Most definitions of the term 'psychosocial' are based on the idea that a combination of psychological and social factors are responsible for the well-being of people, and that these cannot necessarily be separated from one another. For example, the UNHCR uses the term to refer to "the intimate relationship between psychological and social factors" (1994:37). Although there is little agreement as to what exactly constitutes psychosocial assistance to war-affected and displaced communities (Eyber 2002, Loughry & Eyber 2003), the term directs attention to a range of issues that can affect refugee children rather than focusing exclusively on the psychological aspects of health and well-being, and emphasises the need to view these issues within the context of wider family and community networks in which they are located.

Anthropologists recognise that a contextualised approach to childhood is needed (James 1998). Whereas cross-cultural psychiatric research has documented evidence of universal diagnoses of responses to trauma, anthropologists have emphasised cross-cultural variability (Kleinman 1987). Ethnographic accounts have explored the diversity of childhood, charting differences across space and exploring cross-cultural variability and range in children's experience (Panter-Brick 1998, 2000). A psychosocial approach to mental health and well-being recognises that suffering, loss, grief and healing are also experienced in context and psychological distress in response to war trauma is known to be culturally mediated and negotiated through community networks of social support (Ahearn 2000). Social constructions of childhood and trauma are certainly variable and context specific, hence children's responses to adversity cannot be understood in isolation from the social, cultural and moral contexts they inhabit (Boyden & Mann 2000). For example, a focus on individual trauma may underestimate the importance of culturally constructed meanings and interpretations of war related events where psychological wounds cannot be separated from collective wounds (Wessells 1999).

'The Children of Kabul: Discussions with Afghan Families' (de Berry et al 2003) research project endorsed a psychosocial approach to explore children's views and experiences of life in Kabul using participatory research methods such as focus group discussions and drawing activities. Jo de Berry and her colleagues describe well-being for Afghans as including social, emotional, spiritual and physical qualities. Children and parents defined their standards for children's well-being in terms of morality, respect, religious faith, positive feelings, good relationships and correct behaviour. The concept

of *tarbia* refers to children's manners and the quality of their relationships with others. Children with good *tarbia* (*ba tarbia*, or with *tarbia*) were said to be polite, obedient, respectful to their parents and elders, sociable and moral, whereas children with bad *tarbia* (*be tarbia*, or without *tarbia*) were said to be rude, antisocial and argumentative. Other qualities that were considered good for children's well-being were courage (*delair*) to cope with the outside world, religious faith, household responsibility, and positive feelings such as happiness and calmness which will be apparent in their attitudes towards others and their attitude towards the future. Feelings are not just a mental or emotional state but are experienced physically through the body. Negative feelings such as sorrow, distress and anxiety are somatised causing a child to be simultaneously sick and weak.

Psychosocial approaches to mental health move away from pathologising refugee children, making more room for children's competencies and resourcefulness in the face of adversity (e.g. Almqvist 2000, Boyden & Mann 2000, de Berry & Boyden 2000, Ispanovic-Radojkovic 2000, Qouta 2000). Instead of focussing on children as helpless victims of trauma and exploring correlations between stressful life experiences and a range of psychiatric disorders, psychologists and anthropologists seek to promote understanding of resiliency (capacity to adapt) and coping (e.g. Boyden & Mann 2000, Garmezy et al 1984, Luthar et al 2000, Woodhead et al 2003). Research has moved beyond identifying risk factors that render children vulnerable to poor health, developmental delay or negative psychological outcome, to understanding the protective factors and range of coping processes that contribute to positive outcomes. According to James Garbarino and Kathleen Kostelny (1992:16-17), "[refugee] children who can

manage to hold onto a positive world view amidst the desperate pressures of living in chaotic violence and despite having lost their homes are a precious resource". Indeed, refugees have been described as "...perhaps the maximum example of the human capacity to survive despite the greatest of losses and assaults on human identity and dignity" (Muecke 1992:520).

Jo de Berry (2002:1), Children in Crisis Advisor to Save the Children (USA) and consultant on 'The Children of Kabul' project, emphasised the ability of children to cope and overcome adversity: "As I work with Afghan children I am constantly amazed at their resilience and fortitude. They have come through the most terrible of events but are still able to live as children, to play, to learn and to laugh. I do not, generally, find children overwhelmed and incapacitated by trauma but children who have come through suffering with their humanity and hope intact." 'The Children of Kabul' report (de Berry et al 2003) maintains that the majority of children are not completely overcome by the problems and hardship they face. Instead they and their families have many strengths and resources, which they employ to cope with challenges and minimise the adverse affects of those challenges. These resources include a range of attitudes towards suffering, supportive family and social relationships, and being able to share the burden of suffering with those around them. They allow children to cope with the difficulties they face and maintain a positive outlook.

Anthropologists now make a great deal more room for children's own accounts of their lives, as told by the children themselves (Panter-Brick 1998:2). Children are seen as

playing an active part in determining the outcome of adversity (Woodhead et al 2003:23), as agents not victims of change (Boyden & Mann 2000, Panter-Brick 2001, 2002), and as capable and key informants about childhood (Christensen & James 2000, Hardman 1973, cited in James 1998:52-53). For adults to better understand children's problems and needs, they require children to explain and interpret their childhoods (Boyden 2003). Jo de Berry (2003:67) maintains that in the Afghan context it is important to be "...aware of people's own perspectives and beliefs, as well as the context of their lives, to comprehend fully what an event or situation or fact means to them, and how it affects their lives". She goes on to say that what emerges as the children's perspective reveals a strong degree of conformity between children's and adult's views, which reflects the fact that Afghan parents guide their children in how to think about life. In addition to this, unique aspects of children's perspectives confirm the need for an approach that listens to children's own opinions and allows children to participate in identifying problems and creating solutions (2003:70).

iii. Summary of approaches

Table 1.2. The major differences between western biomedical and psychosocial approaches are summarised in the following table:

	Western biomedical approach	**Psychosocial approach**
Focus	Psychological and psychiatric impact of war trauma on child mental health	Impact of a range of factors on children's well-being and social relationships
	Individual children	Children and their families in wider context
Tools	Psychometric screening questionnaires for diagnosis of different disorders, e.g. PTSD	Participatory research methods, e.g. interviews, focus group discussions, projective techniques
Main features	Quantifiable data	Qualitative data
	Etic perspective, based on western biomedical concepts	Emic approach, based on children's own perspectives on well-being and the 'meaning' of adversity
	Treatment-based assistance delivered by expert clinicians	Community-based intervention based on strengthening existing coping resources
	Indicates scale of mental health problems	Prioritises local views on well-being, may romanticise local cultures
	Useful for allocating resources and evaluating intervention programmes	Problematic if community networks have been severely damaged
	Questionable cross-cultural validity	Information about one specific community which cannot be generalised to other contexts

Neither one of these approaches need necessarily preclude the use of the other. Indeed, a multidisciplinary approach can combine the strengths of both approaches by using the persuasiveness of statistical data together with the information-rich data from qualitative research (Ager 2000). There are however few examples of studies of mental health that

have successfully been able to integrate the two approaches. One exception is Carolya Eyber's (2001) study of refugee youth in Angola which employed psychometric questionnaires to appraise the prevalence of anxiety and PTSD, but additionally, anthropological methods to reveal how youth coped with their suffering through peer and community networks of social support. Psychometric data revealed that many children displayed symptoms of mental health problems while anthropological research showed that the same children were functioning well in their ordinary lives. In another study Lynne Jones and Konstantinos Kafetsios (2002) employed a multidisciplinary study to the assessment of adolescent mental health on opposite sides of the Bosnian conflict. They found that symptom checklists corresponded reasonably well with well-being as measured by narrative interviews, lifelines and participant observation, but that in almost a quarter of participants, the presence or absence of symptoms as reported by checklists was misleading as to the well-being of the child according to qualitative research, suggesting that checklists on their own are not an adequate means of clinical screening.

d. Objectives of the study

i. Main objective

The main objective of this study is to employ a clinical tool for screening child mental health, supplemented with anthropologically-informed methods that yield contextual information (children's projective drawings and open-ended interviews), to the study of Afghan refugee children in Pakistan. This study employs a multidisciplinary research approach to screen for individual psychological distress within social context. Quantitative psychometric data and qualitative contextual information complement one another, providing an understanding of the effects of conflict and displacement on Afghan children in Pakistan.

ii. Specific aims

This thesis will: 1) ascertain prevalence estimates for three main categories of mental disorders (emotional, conduct and hyperactivity) and a measure of prosocial strengths for a sample of 11 to 16 year old Afghan children from several school samples in Peshawar (North West Frontier Province, Pakistan); 2) identify factors that account for variation in prevalence rates; and 3) take account of children's own views about their lives and relate these to psychometric data.

This study will evaluate the usefulness of a western biomedical tool, the Strengths and Difficulties Questionnaire (SDQ), as a potential research tool to be used alongside qualitative techniques by anthropologists in non-western settings.

Chapter 2

Methods

a. Research logistics

Fieldwork was conducted in March – April 2003 in Peshawar (North West Frontier Province, Pakistan) with a follow-up in May 2004, under the management of Dr. A.W.H. Wardak, a chartered Psychologist and Associate Fellow of the British Psychological Society, and Dr. Catherine Panter-Brick, who designed the study and received British Academy funding. Dr. A.W.H. Wardak is an Afghan national, and was consequently able to travel and facilitate this research at a time when the Iraq war broke out. The University of Durham had refused permission for me to travel to Pakistan on safety grounds. Upon completion of fieldwork, I resumed all responsibility for data analysis and review of the literature.

b. The research team in Peshawar

The local research team comprised of one male project co-ordinator (Mr. Haaji Israeli), his assistant, and five full-time and five part-time female field assistants. The field assistants were locally recruited school teachers. All members of the research team were Pashto Afghans. All questionnaires used were translated into Pashto by Dr. A.W.H. Wardak in the UK and the parent questionnaire was independently back-translated by Dr. Farouq Azam in Pakistan to ensure accuracy. Dr. A.W.H. Wardak and Dr. Azam also advised on the cultural appropriateness of the questions. The research assistants

administered the questionnaires as structured interviews because the respondents' level of literacy was not usually sufficient for them to complete it directly.

Upon completion of the fieldwork, mistakes in translation were discovered on the teacher and child questionnaires: on the *perceived difficulties* item of the impact supplement, tick-boxes should have represented a 4-point severity scale, not different types of problems (emotions, concentration, behaviour, or being able to get on with other people). Mr. Haaji Israeli returned to Peshawar in May 2004 to re-administer the corrected impact supplement to teachers.

c. Ethical approval and consent procedures

Research permission to work with refugee children in local schools was granted by the Afghan Refugee Commissionorate in Peshawar. The University of Durham also gave prior ethical clearance (application 02 EAC R114). A research summary was translated into Pashto and presented to the head teachers of the sample schools. Informed consent was then sought from school head teachers, children and, where possible, their parents. Due to respondents' level of literacy, consent was verbal rather than written. Anonymity and confidentiality were maintained unless participants wanted to make their real names known.

d. Sample selection

Four different schools were purposively selected within Peshawar (Table 2.1, designated as 'very poor, 'poor', 'affluent' and 'orphaned'). Three of the schools were selected to

include children from different socio-economic groups; the fourth was a school for children exposed to trauma (children orphaned from one or more close relatives). Within the first three schools, a random sample of children was taken from school registers within the specified age range (11 to 16 years). In the fourth school, the teachers themselves suggested eliciting a purposive sample of children who were orphaned from one or both parents, or other close relatives.

Table 2.1. Sample selection of children

Sample	**School name**	**Funding**	**Sampling**
Very poor	Herawi School	UNHCR/IRC	Random (chosen from class list)
Poor	Mariam School	UNHCR/IRC	Random (chosen from class list)
Affluent	Sonia School	Private	Random (chosen from class list)
Orphaned	Farsi School	Private	Purposive (chosen by teachers)

The 'very poor' school was located in a refugee camp in Gulabad and the 'poor' school (Figure 2.1) situated on Nasirbagh Road leading to a refugee camp. These schools were funded by the United Nations High Commissioner for Refugees (UNHCR) and International Rescue Committee (IRC), and students charged only a nominal fee. The 'affluent' and 'orphaned' schools were located in the wealthy area of Hayat Abad; these schools depended entirely upon student fees paid by the children's relatives.

Figure 2.1. Mariam School

Initial contact was made with the schools' headmasters who then contacted the parents. Parents/guardians from the 'very poor', 'poor' and 'orphaned' samples were paid 100 Rupees each to cover travel expenses to come to the school to complete the questionnaires. Parents from the 'affluent' sample were not offered incentive payments, as this would be seen as offensive. All the children in the four schools were given a small gift of a pen and notepad at the end of the study. Research assistants visited schools on prearranged visit days and then asked permission to travel to children's homes to interview parents who were unable to come to the school.

e. 'Child and Family History Questionnaire' and educational attainment

A personal and family history questionnaire (Appendix 2.1) was completed by all the children. This was formulated to elicit relevant socio-demographic information (gender, age, poverty index, family/peer relations, displacement, work and aspirations). Teachers were also asked to record the children's educational attainment levels for their own classes. The questionnaire did not ascertain ethnic group as it was considered that this might be inhibiting for some children of minority status. A full description of variables is given in Table 2.2. Responses to some questions were illegible affecting sample sizes for analyses.

Table 2.2. Description of variables

Variable name		**Definition of measure**	**Type**	**Value in SPSS**	**Value description and range**
School sample		Schools selected purposively (see text)	Categorical	0 1 2 3	Orphaned Very poor Poor Affluent
Gender		Sex	Categorical	1 2	Male Female
Age		Age in years	Continuous	11-16	11-16
Age group		Age in years	Categorical	1 2 3 4	11 12 13 14-16
Index of material poverty		Number of household items (radio, TV, mobile telephone, VCR, satellite dish, tap)	Continuous	0-6	0-6
Family/peer relations	Household size	Number of people living in house	Continuous	3-45	3-43
	Father	Whether or not father lives in house	Categorical	0 1	No Yes
	Extended family size	Number of cousins child knows by name not living in house	Continuous	0-85	0-85
	Friends	Number of friends	Continuous	0-10	0-10
Displacement	Place of birth	Place of birth	Categorical	0 1	Afghanistan Pakistan
	Years in Peshawar	Number of years residing in Peshawar	Continuous	1-16	1-16
Work		Whether or not the child works	Categorical	0 1	No Yes
Educational score		Educational score	Categorical	1 2 3	A (high) B C (low)
Aspirations		Reported education and job aspirations	Categorical	0 1	Education Job

f. 'Strengths and Difficulties Questionnaire' (SDQ)

i. Scoring items

The SDQ asks about 25 psychological attributes, some positive and others negative. These 25 items are divided between 5 scales (Goodman 1997) (Table 2.3).

Table 2.3. Scores generated by Strengths and Difficulties Questionnaire

Scale	**Item**[1]
Emotional symptoms	Often complains of headaches, stomachache or sickness; Many worries, often seems worried; Often unhappy, downhearted or tearful; Nervous or clingy in new situations, easily loses confidence; Many fears, easily scared.
Conduct problems	Often has temper tantrums or hot tempers; *Generally obedient, usually does what adults request*; Often fights with other children or bullies them; Often lies or cheats; Steals from home, school or elsewhere.
Hyperactivity/inattention	Restless, overactive, cannot stay still for long; Constantly fidgeting or squirming; Easily distracted, concentration wanders; *Thinks things out before acting*; *Sees tasks through to the end, good attention span.*
Peer relationship problems	Rather solitary, tends to play alone; *Has at least one good friend*; *Generally liked by other children*; Picked on or bullied by other children; Gets on better with adults than other children.
Prosocial behaviour	Considerate to other people's feelings; Shares readily with other children (treats, toys, pencils etc.); Helpful if someone is hurt, upset or feeling ill; Kind to younger children; Often volunteers to help others (parents, teachers, other children).

[1]Items printed in italics scored in reverse direction
Adapted from Goodman (1997:582)

The same 25 items are included in questionnaires for completion by the parents (P4-16 SDQ) or teachers (T4-16 SDQ) of 4–16 year olds. Questionnaires for self-completion by adolescents ask about the same 25 traits, though the wording is slightly different. This self-report version (S11-16 SDQ) is suitable for young people aged around 11-16, depending on their level of understanding and literacy.

As outlined in Goodman 1997, each item on the questionnaires can be marked 'not true', 'somewhat true' or 'certainly true'. For all of the items except the five printed above in italics, the item is scored 0 for 'not true', 1 for 'somewhat true' and 2 for 'certainly true'. For the five items printed in Table 2.3 in italics, the item is scored 2 for 'not true', 1 for 'somewhat true' and 0 for 'certainly true'. The score for each of the five scales is generated by summing the scores for the five items that make up that scale, thereby generating a scale score ranging from 0 to 10. The scores for emotional, conduct, hyperactivity and peer problems can be summed to generate a total difficulties score (TDS) ranging from 0 to 40; the prosocial score is not incorporated in the opposite direction in the TDS since the absence of prosocial behaviours is not equivalent to the presence of psychological difficulties.

ii. Scoring bands for SDQ ratings

The cut-off points suggested by Goodman (Goodman 1997, Goodman et al 1998) to demarcate 'normal' versus 'abnormal' scores for mental health problems are given in Table 2.4. These bands, which have not been adjusted for age or gender, have been chosen so that in a community sample roughly 80% of 11 to 16 year olds are 'normal',

10% are 'borderline' and 10% are 'abnormal', based on a number of epidemiological surveys using the SDQ.

Table 2.4. Scoring for mental health ratings

Scale			Normal	Borderline	Abnormal
Total difficulties		Parent	0-13	14-16	17-40
		Teacher	0-11	12-15	16-40
		Self	0-15	16-19	20-40
Subscales	Emotional	Parent	0-3	4	5-10
		Teacher	0-4	5	6-10
		Self	0-5	6	7-10
	Conduct	Parent	0-2	3	4-10
		Teacher	0-2	3	4-10
		Self	0-3	4	5-10
	Hyperactivity/ inattention	Parent	0-5	6	7-10
		Teacher	0-5	6	7-10
		Self	0-5	6	7-10
	Peer relationships	Parent	0-2	3	4-10
		Teacher	0-3	4	5-10
		Self	0-3	4-5	6-10
Prosocial behaviour		Parent	10-6	5	4-0
		Teacher	10-6	5	4-0
		Self	10-6	5	4-0

Adapted from http://www.sdqinfo.com

The selection of the SDQ items and their grouping into scales is based on current diagnostic criteria as well as factor analyses (Goodman & Scott 1999, Goodman 2001). The relevant concepts are those that underpin the DSM-IV (American Psychiatric Association 1994) and ICD-10 (World Health Organisation 1994) classifications of childhood psychopathology. For example, the five items comprising the hyperactivity/inattention scale were deliberately selected to tap inattention (two items), hyperactivity (two items) and impulsivity (one item) because these are the three symptom

domains for a DSM-IV diagnosis of attention-deficit/hyperactivity disorder (ADHD) (APA 1994) or for an ICD-10 diagnosis of hyperkinesis (WHO 1994) (Goodman & Scott 1999, Goodman 2001).

iii. Impact supplement

The extended version of the SDQ, including an impact supplement, was selected for this study. As specified in Goodman 1999, the impact supplement focuses on four domains in the P4-16 and S11-16 versions of the SDQ: home life, friendships, classroom learning and leisure activities. These four domains are the main areas that need to be considered when rating psychosocial disability using the WHO's classification of child and adolescent psychiatric disorders (WHO 1996, cited in Goodman 1999). The T4-16 version differs in the omission of the two impairment items on home life and leisure (as teachers will often be unable to provide informed answers on these issues).

The first question on each section of the impact supplement asks respondents if they think the young person has difficulties in one or more of the following areas: emotions, concentration, behaviour, or being able to get on with other people. The response to this *perceived difficulties* item is rated on a 4-point severity scale: 0 = no, 1 = minor, 2 = definite, 3 = severe. When respondents perceive no difficulties, it makes no sense to ask them about the chronicity, impact or burden of difficulties; these respondents are allowed to skip all these items which are coded as zero. Only those respondents who perceive minor, definite, or severe difficulties are asked to complete the remaining items.

The 'chronicity rating' is scored as: 1 = less than a month, 2 = 1-5 months, 3 = 6-12 months, 4 = over a year. The 'impact rating' (Table 2.5) is scored by adding the scores on the *distress* and social *incapacity* items using a '0012' scale for each item: 0 = not at all/only a little, 1 = quite a lot, 2 = a great deal. In effect, the algorithm disregards reports of 'only a little' distress or social incapacity as clinically irrelevant. Using the 0012 scoring system, a child needs to have 'quite a lot' of distress or impairment in at least one domain before the impact score rises above zero. A 'burden rating' is calculated from response to the burden question rated on a 4-point scale: 0 = not at all, 1 = only a little, 2 = quite a lot, 3 = a great deal.

Table 2.5. Generating and interpreting impact scores

Scale			Not at all	Only a little	Quite a lot	A great deal
Difficulties upset or distress child		Parent	0	0	1	2
		Teacher	0	0	1	2
		Self	0	0	1	2
Domains difficulties interfere with:	Home life	Parent	0	0	1	2
		Teacher	-	-	-	-
		Self	0	0	1	2
	Friendships	Parent	0	0	1	2
		Teacher	0	0	1	2
		Self	0	0	1	2
	Classroom learning	Parent	0	0	1	2
		Teacher	0	0	1	2
		Self	0	0	1	2
	Leisure activities	Parent	0	0	1	2
		Teacher	-	-	-	-
		Self	0	0	1	2

Adapted from http://www.sdqinfo.com

iv. Predictive algorithm

A computerised algorithm (available on http://www.sdqinfo.com) predicts psychiatric diagnoses on the basis of the symptom (emotional, conduct and hyperactivity) and impact scores (chronicity and burden ratings are not included). In this study, only parent and teacher-rated impact scores were entered into the algorithm due to mistakes in translation in the self-report *perceived difficulties* item. The predictive algorithm generates **'unlikely'**, **'possible'** or **'probable'** ratings for three groups of disorder: emotional, conduct and hyperactivity, which are also combined to generate an overall prediction about the presence or absence of 'any psychiatric disorder' (Goodman et al 2000a, Goodman et al 2000b). A simplified version of the SDQ criteria for suspecting 'probable' disorders is summarised in Table 2.6. Predictions of 'possible' disorders are generated when the combination of high symptom and high impact scores is not met.

Table 2.6 Criteria for suspecting 'probable' psychiatric disorder on the basis of individual SDQ scores

Informant	Probable cases of			
	Emotional	Conduct	Hyperkinetic	'Any' psychiatric disorder
Parent SDQ only	Symptom >7 Impact >2	Symptom >6 Impact >2	Symptom >8 Impact >2	Meets any of the criteria to the left
Teacher SDQ only	Symptom >6 Impact >2	Symptom >6 Impact >2	Symptom >8 Impact >2	Meets any of the criteria to the left
Self-rated SDQ only	Symptom >8 Impact >2	Symptom >6 Impact >2	Symptom >7 Impact >2	Meets any of the criteria to the left
Multi-informant SDQ	Any of the above	Any of the above	Any 2 of the above	Meets any of the criteria to the left

Adapted from Mullick & Goodman (2001:97).

g. Open-ended interviews

Qualitative study was undertaken making use of open-ended interviews with 20 children (10 boys and 10 girls) aged 11 to 16 years. These children were selected by the teachers to be interviewed in Pashto by the female field assistants. Interviews were conducted in an empty classroom with children in the 'very poor', 'poor' and 'orphaned' school samples. The interviews, designed to provide contextual information, included a one day recall, good and bad aspects of living in Peshawar, things that make the child feel happy and sad, family and friends as sources of support, political awareness, impact of war and future aspirations. Some example interview questions are reproduced in Appendix 2.2. The head teachers from the 'poor' and 'orphaned' schools were also interviewed about

life in Peshawar. Interviews were audio-taped and on return to the UK transcribed and translated by Dr. A.W.H. Wardak.

h. Projective techniques

Projective techniques were used in order to evaluate children's self-perceptions and future aspirations, and acquire some sense of children's priorities and values. The children were provided with paper and coloured pencils and asked to draw two pictures depicting themselves in the present and what they imagined in the future. The children were not obliged to write their names but chose to do so. Many drawings were collected and for purposes of this thesis the drawings of 2 boys and 4 girls aged 11 to 15 from the 'poor' school were selected to illustrate recurrent themes.

i. Analyses

Data from the SDQ algorithm were exported to a SPSS data file generating two types of data: 1) continuous TDS and prosocial scores, and 2) categorical mental health ratings based on combined symptom and impact scores. The distribution of all variables was tested for significant departure from a normal distribution using the Kolmogorov–Smirnov test. Differences across groups were analysed using ANOVA for normally distributed data and Kruskal-Wallis test for non-parametric data. Pearson's Chi-Square was used to examine differences across categorical variables.

Multivariate stepwise regression models were run to ascertain the relative significance of selected variables. Logistic regressions were used where variables were categorical or

distribution of residuals was non-normal. Initial regression models included school sample, gender and age as predictor variables. Displacement, family/peer relations and mental health ratings were added step-by-step to further models. Interrater correlations were tested for significance using Pearson's Correlation Coefficient or Spearman's rho where data distribution was skewed. All data analyses were undertaken using the statistical package SPSS version 11.0 (SPSS Inc. 2001). Values of $p<0.05$ were taken as significant.

The content of the interviews and drawings was analysed and found to highlight several themes about children's lives. Quotes and drawings illustrating these themes were selected for inclusion in the thesis. It was not the aim of this study to systematically analyse the content or style of the drawings according a projective test.

Chapter 3

Results on psychometric questionnaire

The results presented in this chapter focus on a) describing the sample of refugee children; b) estimating prevalence of common child mental health disorders in the chosen schools of Peshawar, and where appropriate comparing them to data for the British norm (Goodman, personal communication, based on data from Meltzer et al 2003), refugee children attending school in the UK (Fazel & Stein 2003), and school children from two diverse cultural contexts, Bangladesh (Mullick & Goodman 2001) and Brazil (Fleitlich–Bilyk 2002); c) establishing factors (school sample, gender and age) which account for variation in mental health ratings; and 4) comparing ratings by type of informant.

The chapter concludes with a summary of findings.

a. Sample characteristics

i. Participants

A total of 128 children were approached, all of whom agreed to participate in the study. Table 3.1 shows the number of questionnaires obtained from the different respondents. There were some missing forms, particularly where parent-rated: only 18 parents of a total of 40 children in the 'affluent' school completed the SDQ. This was because this group of parents proved more difficult to persuade to take time to complete questionnaires. Self-rated impact scores were not entered into the computerised algorithm due to a translation mistake in the questionnaire.

Table 3.1. Parent, teacher and self-report SDQ completion rates

Respondents	**School**				**Total**
	Very poor	Poor	Affluent	Orphaned	
Number approached	33	35	40	20	128
Parent	33	35	18	19	105 (82%)
Teacher	29	35	40	17	121 (95%)
Self	32	35	40	20	127 (99%)
Achieved sample	33	35	40	20	128 (100%)
Sub-set with 3 respondents[1]	29	35	18	17	99 (77%)

[1] Informant participation rates compare favourably to other studies: data collected from parents (100%), teachers (68%) and self (93%) for British norm (Goodman, personal communication), based on '1999 British Child and Adolescent Mental Health Survey' (Meltzer et al 2003); data collected from 2+ informants in 98% of cases and 3 informants in 47% of cases for Brazil study (Fleitlich-Bilyk 2002).

ii. Age, gender and economic characteristics

The children were aged between 11 and 16 years. The total sample is unevenly distributed across different ages (X^2=56.97, 5df, p<0.0001), with fewer children aged 14 to 16. The median age of the children was 12 years. Overall, almost twice as many boys as girls participated in the study (X^2=10.13, 1df, p=0.001). School visits were not orientated to obtaining an equal proportion of boys and girls. Because more visits to schools occurred in the morning, and classes for boys were held in the mornings whereas classes for girls were held in the afternoon, boys are over-represented in the sample.

The four school samples do not differ by age, but do differ by gender (Table 3.2, p=0.001), with the proportion of males ranging from 42% in the 'very poor' school to 89% in the 'poor' school. The use of school as a proxy for economic status was confirmed by an index of material poverty (p<0.0001) measured by number of household amenities (radio, TV, mobile telephone, VCR, satellite dish and tap).

Table 3.2. Age, gender and economic characteristics of school samples

		School				**Total**
		Very poor	Poor	Affluent	Orphaned	
	N	33	35	40	20	128
Age[1]	Mean	12.76	11.97	12.18	13.05	12.41
	Median	12.00	12.00	12.00	12.50	12.00
	SD	1.77	0.89	1.01	1.88	1.42
Gender[2]	Male	14 (42%)	31 (89%)	23 (58%)	14 (70%)	82 (64%)
	Female	19 (58%)	4 (11%)	17 (43%)	6 (30%)	46 (36%)
Poverty index[3]	Mean	0.97	1.89	4.47	2.25	2.52
	Median	1.00	2.00	5.00	2.00	2.00
	SD	0.85	1.45	1.06	0.85	1.78

[1] Kruskal-Wallis Test, X^2=5.59, 3df, p=0.133, NS differences by age
[2] Pearson's X^2=16.90, 3df, p=0.001 for differences by gender
[3] Kruskal-Wallis Test, X^2=77.00, 3df, p<0.0001 for differences by poverty index

iii. Distribution of mental health scores

The parent-rated and self-rated total difficulties scores are distributed normally while the distribution for the teacher-rated data is slightly skewed (Table 3.3, Kolmogorov-Smirnov test, p=0.041). The distribution of scores for the predictive diagnoses, the four sub-scales that comprise the TDS (emotional, conduct, hyperactivity/inattention and peer relationship problems), and the prosocial scores are all non-parametric (Table 3.3). The histograms for 'strengths' and 'difficulties' scores are shown in Figure 3.1, and subscale scores are shown in Appendix 3.1.

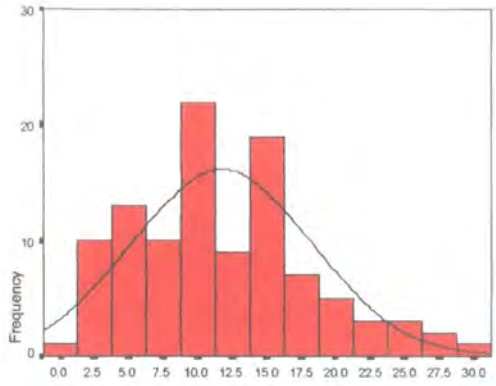
Table 3.3. Distribution of strengths and difficulties scores, with test for skewness

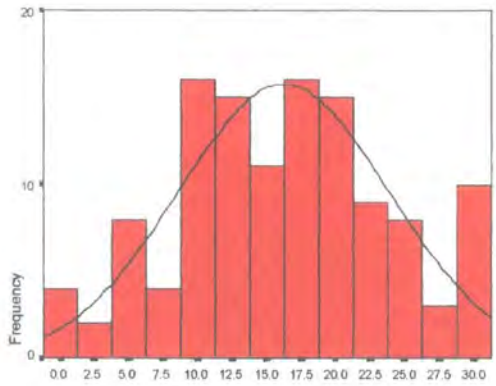
	Respondent					**Kolmogorov-Smirnov**		
		N	Mean	Median	SD	Statistic	df	Sig.
Total difficulties	Parent	105	11.72	11.00	6.483	0.081	98	NS
	Teacher	121	16.21	17.00	7.646	0.092	98	0.041
	Self	127	10.95	11.00	5.419	0.086	98	NS
Emotional symptoms	Parent	105	4.91	5.00	2.945	0.096	105	0.019
	Teacher	121	4.63	5.00	2.656	0.084	121	0.035
	Self	127	4.98	5.00	2.647	0.107	127	0.001
Conduct problems	Parent	105	1.69	1.00	1.878	0.195	105	0.000
	Teacher	121	3.30	3.00	2.505	0.118	121	0.000
	Self	127	1.90	2.00	1.642	0.168	127	0.000
Hyperactivity/ inattention	Parent	105	3.00	3.00	2.422	0.155	105	0.000
	Teacher	121	4.39	5.00	2.709	0.125	121	0.000
	Self	127	2.01	2.00	1.966	0.209	127	0.000
Peer relationship problems	Parent	105	2.14	2.00	1.847	0.159	105	0.000
	Teacher	121	3.90	4.00	1.989	0.125	121	0.000
	Self	127	2.08	2.00	1.744	0.203	127	0.000
Prosocial behaviour[1]	Parent	105	8.61	10.00	1.924	0.262	98	0.000
	Teacher	121	6.88	7.00	2.074	0.116	98	0.003
	Self	127	9.50	10.00	0.925	0.410	98	0.000

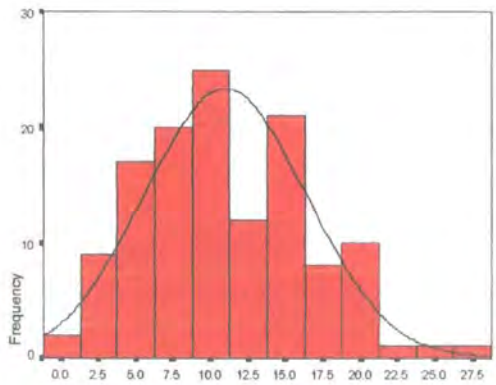
[1] Log10 and Natural log of prosocial scores do not correct skewness of data distribution (Kolmogorov-Smirnov, p<0.0001).

Figure 3.1. Histograms showing distribution of prosocial strengths and total difficulties scores

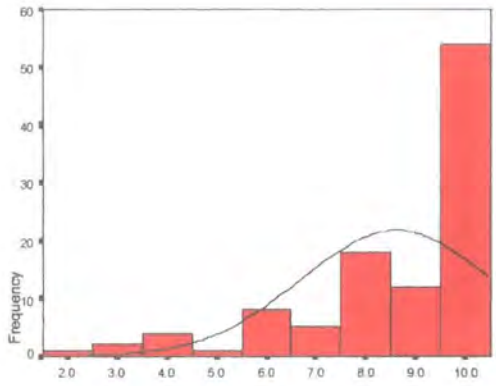
Total difficulties scores

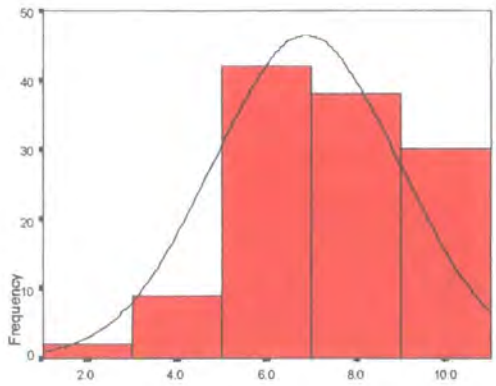


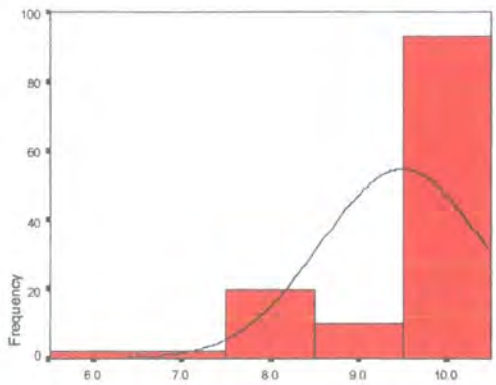




Prosocial scores







b. Proportion of children with a diagnosis of mental health disorder

i. Prevalence rates for types of disorders

The data show that 28 children had a 'probable' psychiatric disorder, giving an overall prevalence rate of 28/128 (22%), double the norm for British children (11%). This compares to 13% for school children in Brazil, 18% for school children in Bangladesh and 27% for refugee children attending school in the UK (Table 3.4). A further 46% of Afghan children in the sample were 'possible' cases for disorders, more than double the norm for British children (20%).

The 28 'probable' cases in this study included 19 boys and 9 girls, aged 11 to 16 years. Roughly equal numbers of children were born in Afghanistan and Peshawar. 21 (16%) of the children were 'probable' cases for behavioural disorders and 7 (6%) of the children were 'probable' cases for emotional disorders. There were no 'probable' cases for hyperactivity disorders. Recall that these 'probable' ratings are based on symptom scores as rated by all respondents and impact scores as rated by adult informants.

Table 3.4. Prevalence of psychiatric disorders, as predicted by algorithm

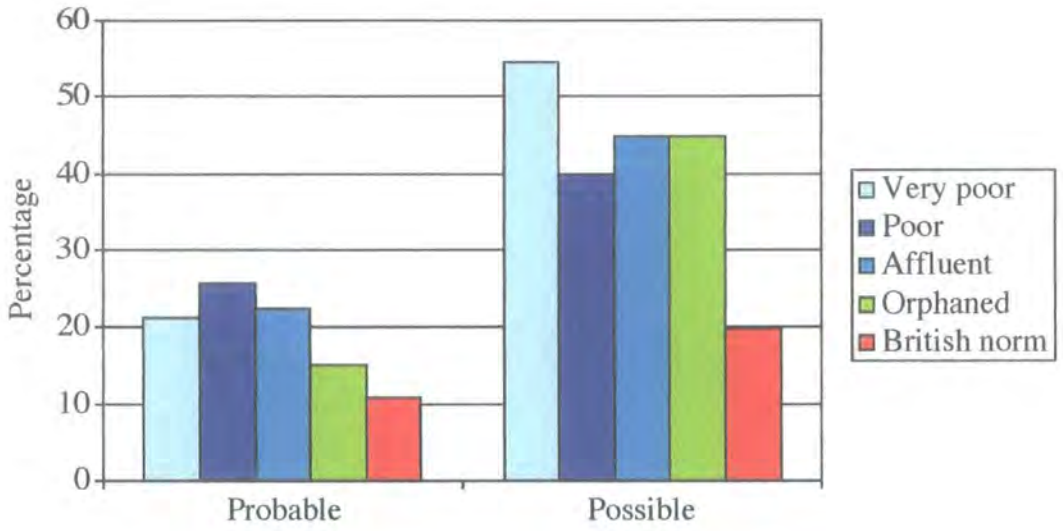
	Rating	Afghan sample in Peshawar[1]		Refugee sample in UK[2]		Bangladeshi sample[3]		Brazilian sample[4]		British norm[5]	
		Freq N=128	%	Freq N=101	%	Freq N=162	%	Freq N=1251	%	Freq N=4300	%
Likelihood of any disorder	Unlikely	41	32.0	n/a	n/a	n/a	n/a	n/a	n/a	2979	69.3
	Possible	59	46.1		n/a		n/a	n/a	n/a	856	19.9
	Probable	28	**21.9**		**27**		**17.9**	147	**12.5**	465	**10.8**
Emotional	Unlikely	95	74.2	n/a	n/a	n/a	n/a	n/a	n/a	3779	87.9
	Possible	26	20.3				n/a		n/a	352	8.2
	Probable	7	**5.5**				**10.5**		**5.9**	169	**3.9**
Behavioural	Unlikely	51	39.8	n/a	n/a	n/a	n/a	n/a	n/a	3301	76.8
	Possible	56	43.8				n/a		n/a	713	16.6
	Probable	21	**16.4**				**5.6**		**7.0**	286	6.2
Hyperkinetic	Unlikely	115	89.8	n/a	n/a	n/a	n/a	n/a	n/a	3885	90.3
	Possible	13	10.2				n/a		n/a	327	7.6
	Probable	0	**0.0**				**3.1**		**1.5**	88	**2.0**

[1] This study, data for 11-16 year olds
[2] Fazel and Stein 2003, data for 5-18 year olds
[3] Mullick & Goodman 2001, data for 4–16 year olds
[4] Fleitlich-Bilyk 2002, data for 7-14 year olds (N=898 in Fleitlich & Goodman (2001) whereas this study uses figures from Fleitlich-Bilyk (2002) which gives more detailed results)
[5] Goodman, personal communication, data for 11-15 year olds in '1999 British Child and Adolescent Mental Health Survey' (Meltzer et al 2003)

ii. Prevalence rates by school sample

Interestingly, the lowest prevalence rate for 'any psychiatric disorder' is for the 'orphaned' school where only 3 (15%) children were rated as 'probable' cases compared with 9 children (26%) in the 'poor' school (Figure 3.2). Differences in proportions across schools are not statistically significant (Table 3.5). Across all schools 40-55% of children are 'possible' cases for a psychiatric disorder.

Figure 3.2. Prevalence of 'any psychiatric disorder' by school samples for Afghan study and British norm



Keeping with the 'probable' ratings, only children from the 'very poor' and 'poor' schools met case criteria for emotional disorders, whereas there were 'probable' cases for behavioural disorders across all schools (ranging from 9% in the 'very poor' school to 23% in the 'poor' school).

Table 3.5. Prevalence of different types of psychiatric disorders by school sample (percentages)

	Rating	**School**			
		Very poor N=33	Poor N=35	Affluent N=40	Orphaned N=20
Likelihood of any disorder[1]	Unlikely	24.2	34.3	32.5	40.0
	Possible	54.5	40.0	45.0	45.0
	Probable	**21.2**	**25.7**	**22.5**	**15.0**
Emotional[2]	Unlikely	60.6	80.0	77.5	80.0
	Possible	27.3	11.4	22.5	20.0
	Probable	12.1	8.6	0.0	0.0
Behavioural[3]	Unlikely	39.4	42.9	37.5	40.0
	Possible	51.5	40.0	40.0	45.0
	Probable	9.1	17.1	22.5	15.0
Hyperkinetic	Unlikely	93.9	82.9	87.5	100.0
	Possible	6.1	17.1	12.5	0.0
	Probable	0.0	0.0	0.0	0.0

[1] Pearson's X^2=1.59, 3df, p=0.662, NS for differences between schools (unlikely vs. possible & probable)
[2] Pearson's X^2=4.38, 3df, p=0.223, NS for differences between schools (unlikely vs. possible & probable)
[3] Pearson's X^2=0.23, 3df, p=0.973, NS for differences between schools (unlikely vs. possible & probable)

iii. Prevalence rates by gender and age

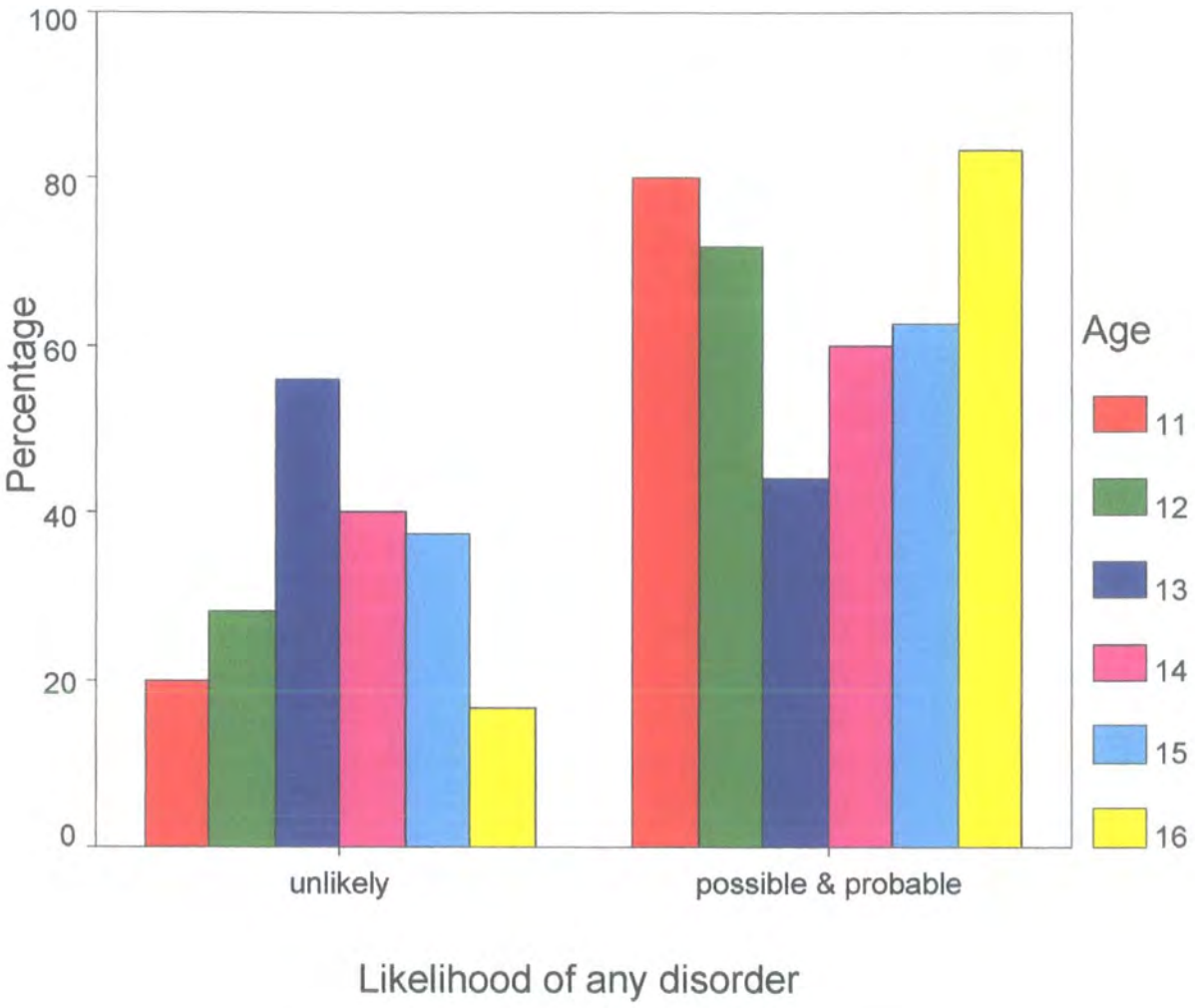
The likelihood of children having at least one psychiatric disorder does not vary significantly with gender but does vary with age group (p=0.029) (Table 3.6, ages 14-16 combined to allow enough data for X^2 analysis). Figure 3.3 shows that the youngest and oldest children are most likely to receive 'possible' or 'probable' ratings.

Table 3.6. Prevalence of psychiatric disorders by gender and age group (percentages)

	Rating	**Gender**		**Age group**			
		M N=82	F N=46	11 N=40	12 N=39	13 N=25	14-16 N=24
Likelihood of any disorder[1]	Unlikely	32.9	30.4	20.0	28.2	56.0	33.3
	Possible	43.9	50.0	60.0	48.7	16.0	50.0
	Probable	**23.2**	**19.6**	**20.0**	**23.1**	**28.0**	**16.7**
Emotional[2]	Unlikely	76.8	69.6	77.5	66.7	76.0	79.2
	Possible	20.7	19.6	15.0	30.8	12.0	20.8
	Probable	2.4	10.9	7.5	2.6	12.0	0.0
Behavioural[3]	Unlikely	40.2	39.1	27.5	41.0	60.0	37.5
	Possible	39.0	52.2	60.0	38.5	24.0	45.8
	Probable	20.7	8.7	12.5	20.5	16.0	16.7
Hyperkinetic	Unlikely	89.0	91.3	87.5	87.2	92.0	95.8
	Possible	11.0	8.7	12.5	12.8	8.0	4.2
	Probable	0.0	0.0	0.0	0.0	0.0	0.0

[1] Pearson's X^2=0.47, 2df, p=0.791, NS differences between genders (unlikely vs. possible vs. probable)
Pearson's X^2=14.03, 6df, p=0.029 for differences between age groups (unlikely vs. possible vs. probable)
[2] Pearson's X^2=0.81, 1df, p=0.367, NS for differences between genders (unlikely vs. possible & probable)
Pearson's X^2=1.74, 3df, p=0.629, NS for differences between age groups (unlikely vs. possible & probable)
[3] Pearson's X^2=3.78, 2df, p=0.151, NS for differences between genders (unlikely vs. possible vs. probable)
Pearson's X^2=6.86, 3df, p=0.077, NS for differences between age groups (unlikely vs. possible & probable)

Figure 3.3. Likelihood of 'any disorder' by age



iv. Logistic regressions predicting likelihood of disorders

So far the affects of school, gender and age on mental health have been examined separately. Logistic regressions were used to analyse these variables simultaneously to see which ones best predicted data variation[7]. 4 separate regressions were conducted for likelihood of 'any disorder', 'emotional disorder', 'behavioural disorder', and 'hyperactivity disorder'. No variables were significant in predicting mental health ratings except school (p=0.015) and the interactive variable age*gender (p=0.026) to predict the 7 probable cases of emotional disorder (unlikely & possible vs. probable, results not tabulated).

[7] 'Age group' was not included in these analyses because there was too much heterogeneity to justify combining ages 14-16 (Figure 3.3).

c. Mental health scores: strengths and difficulties

Continuous dimensional measures of mental health, total difficulties scores (i.e. difficulties) and prosocial scores (i.e. strengths), are now examined in turn and compared with the norm for British children (Meltzer et al 2003) and refugee children in the UK (Fazel & Stein 2003)[8]. The TDS are based entirely on reported symptoms and do not include impact (i.e. whether the person in question is experiencing substantial distress or social impairment).

i. Total difficulties scores (TDS)[9]

Using Goodman's (1997) provisional bandings (Methods, Table 2.4), this sample of Afghan children falls within the normal range as rated by parents and self, and just within the abnormal range as rated by teachers (Table 3.7). While parent and self-rated scores for the Afghan sample and the British norm are remarkably similar, the Afghan teacher-rated scores are elevated by comparison to the British norm and refugee children in the UK.

ii. Prosocial scores[10]

The sample also falls within the normal range for prosocial scores as rated by parents, teachers and self (Table 3.7). The Afghan scores are very similar to those reported for other studies, even where rated by teachers.

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[8] Data unavailable for Bangladeshi (Mullick & Goodman 2001) and Brazilian (Fleitlich-Bilyk 2002) samples.

[9] Total difficulties scores rated by different informants are abbreviated as *p*TDS where parent-rated, *t*TDS where teacher-rated and *s*TDS where self-rated.

[10] Prosocial scores rated by different informants are abbreviated as *p*PROSOC where parent-rated, *t*PROSOC where teacher-rated and *s*PROSOC where self-rated.

Table 3.7. Strengths and difficulties scores as rated by different informants

			Afghan sample in Peshawar	Refugee sample in UK[1]	British norm[2]
TDS	Parent	Mean	11.72	n/a	8.2
		Median	11.00		n/a
		N	105		4443
		SD	6.48		5.8
		Rating	Normal		Normal
	Teacher	Mean	16.21	n/a	6.3
		Median	17.00	9	n/a
		N	121	101	3407
		SD	7.65	n/a	6.1
		Rating	Abnormal	Normal	Normal
	Self	Mean	10.95	n/a	10.3
		Median	11.00		n/a
		N	127		4228
		SD	5.42		5.2
		Rating	Normal		Normal
Prosocial	Parent	Mean	8.61	n/a	8.6
		Median	10.00		n/a
		N	105		4443
		SD	1.92		1.6
		Rating	Normal		Normal
	Teacher	Mean	6.88	n/a	7.1
		Median	7.00	6	n/a
		N	121	101	3407
		SD	2.07	n/a	2.4
		Rating	Normal	Normal	Normal
	Self	Mean	9.50	n/a	8.0
		Median	10.00		n/a
		N	127		4228
		SD	0.93		1.7
		Rating	Normal		Normal

[1] Fazel & Stein 2003, data for 5-18 year olds

[2] Available at http://www.sdqinfo.com, data for 11-15 year olds

iii. Four subscale scores

The four subscale scores that comprise the total difficulties score were analysed separately. The worst scores are those of the emotional symptoms scale with a borderline teacher rating and abnormal parent rating. The teachers also give borderline ratings for conduct and peer relationship problems. The best scores are those of the hyperactivity/inattention scale for which the Afghan children were rated as normal by parent, teacher and self. By comparison, all British scores are normal (Appendix 3.2).

iv. Ratings by school sample, gender and age

As rated by parent and self, all four schools received normal total difficulties ratings. As rated by teacher, the 'very poor' and 'orphaned' schools received abnormal ratings whereas the 'poor' and the 'affluent' schools received borderline ratings. As for prosocial scores, all respondents rated the four groups of children as normal (Table 3.8). There were no significant gender differences for either TDS or prosocial scores (results not tabulated). There were significant differences in TDS by age as rated by teacher (p=0.005) and self (p=0.017) with the youngest and oldest children showing the worst scores (Figure 3.4). Prosocial scores did not vary by age.

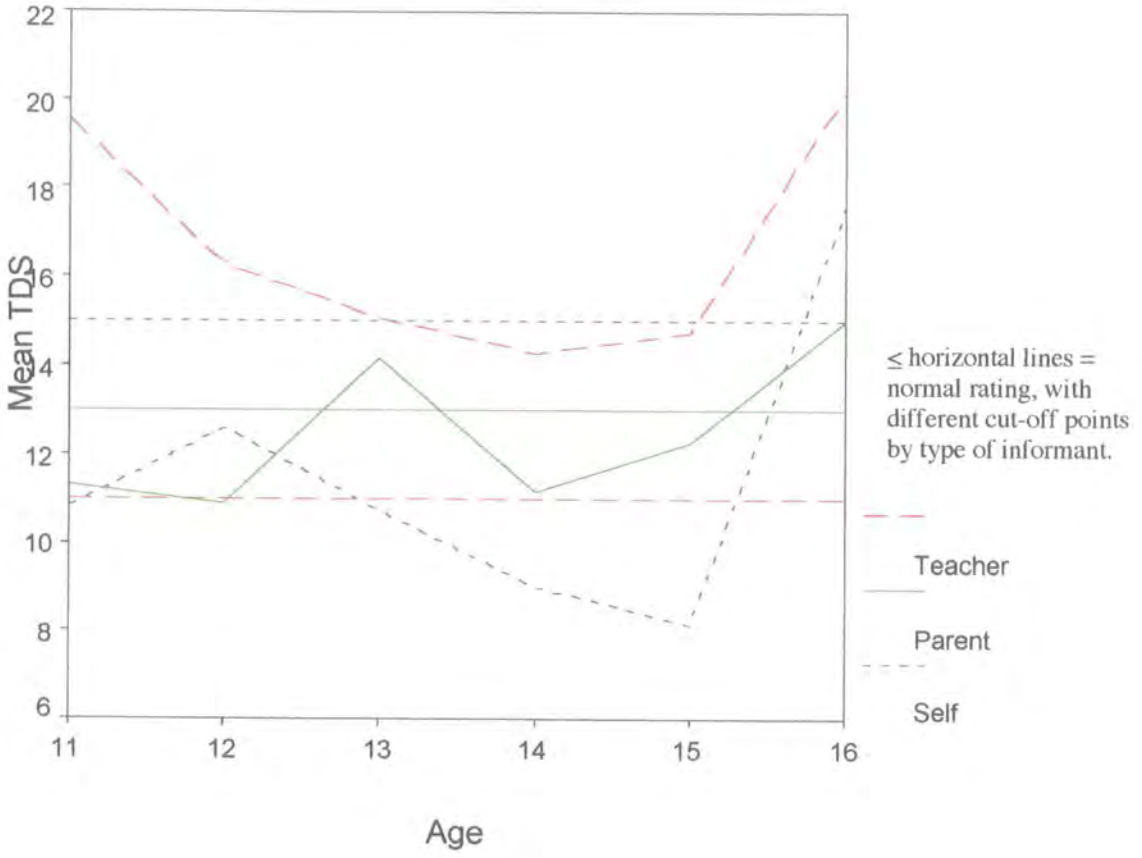
Table 3.8. Strengths and difficulties scores by school sample

			School				Differences
			Very poor	Poor	Affluent	Orphaned	
TDS	Parent	Mean	12.85	10.09	10.50	13.95	NS
		Median	12.00	10.00	9.00	14.00	
		N	33	35	18	19	
		SD	6.90	6.23	6.45	5.59	
		Rating	Normal	Normal	Normal	Normal	
	Teacher	Mean	19.10	16.06	14.00	16.76	p=0.0531
		Median	20.00	14.00	14.00	17.00	p=0.0712
		N	29	35	40	17	
		SD	7.50	7.82	8.12	4.62	
		Rating	Abnormal	Borderline	Borderline	Abnormal	
	Self	Mean	11.44	10.97	11.05	9.95	NS
		Median	11.00	9.00	9.50	9.50	
		N	32	35	40	20	
		SD	4.92	5.70	5.66	5.46	
		Rating	Normal	Normal	Normal	Normal	
Prosocial	Parent	Mean	9.30	8.23	8.17	8.53	NS
		Median	10.00	9.00	9.00	10.00	
		N	33	35	18	19	
		SD	1.19	2.00	2.36	2.17	
		Rating	Normal	Normal	Normal	Normal	
	Teacher	Mean	7.00	6.89	7.08	6.24	NS
		Median	7.00	7.00	7.50	6.00	
		N	29	35	40	17	
		SD	1.91	2.31	2.08	1.86	
		Rating	Normal	Normal	Normal	Normal	
	Self	Mean	9.47	9.37	9.70	9.35	NS
		Median	10.00	10.00	10.00	10.00	
		N	32	35	40	20	
		SD	0.92	0.97	0.72	1.18	
		Rating	Normal	Normal	Normal	Normal	

[1] ANOVA, 3df, F=2.64, p=0.053 for differences between schools

[2] Kruskal-Wallis, X^2=7.01, 3df, p=0.071 for differences between schools (analysis repeated with non-parametric test because teacher-rated data are slightly skewed).

Figure 3.4. Total difficulties scores as rated by type of informant, for children of different ages (high values indicate worst outcomes)



v. Regression analyses with school sample, gender and age

Stepwise linear regression analyses were carried out to examine data variation by school, gender and age (Table 3.9) and where appropriate logistic regressions were used to examine normal versus borderline & abnormal scores. There were differences between schools where TDS were parent-rated (p=0.026) and teacher-rated (p=0.005). As might be expected, children from the 'affluent' school showed marginally better scores than those in other schools, but contrary to expectation, the 'orphaned' did not distinguish themselves from other children in terms of their total difficulties scores. There was also a significant effect for age where scores were teacher-rated (p=0.007), with younger children showing worse scores than their older counterparts. In these models there are no detectable differences for total difficulties scores by gender. For prosocial scores, school, gender and age make no impact on the logistic regressions (results not tabulated).

Table 3.9. Stepwise linear regressions for total difficulties scores (TDS) as rated by different respondents

Dependent variable	**N**	**Predictors**[1,2]	**R^2**	**F**	**B**	**SE**	**t**	**Sig.**
*p*TDS	105	School	0.05	5.09	-1.43	0.64	-2.26	0.026
*t*TDS	121	School Age	0.10	6.33	-1.89 -1.37	0.66 0.50	-2.87 -2.74	0.005 0.007
*s*TDS	127	.	.	.	.	.	.	.

[1] Predictor variables were school, gender and age. Only significant variables are shown.
[2] Regressions were also run including interactive factors for school, gender and age with much the same results. For *p*TDS, school (p=0.001) and the interaction school*age*gender (p=0.009) were significant (R^2 =0.11, p=0.003); and for *t*TDS, the interaction school*age (p=0.004) and age (p=0.017) were significant (R^2=0.10, p=0.002).

vi. Further regression analyses

Further regression analyses were conducted taking into account not only school, gender and age but also scores given by other respondents (Tables 3.10 & 3.11). For instance, a model was constructed to predict variation in *p*TDS from school, gender, and age, along with *t*TDS and *s*TDS. For *p*TDS, gender (p=0.026) as well as school (p=0.025) explained 10% of the variance (only 5% was explained in Table 3.9): girls were more likely to have mental health problems than boys. Teacher and self-rated scores were closely correlated (p=0.007).

Table 3.10. Further stepwise linear regressions to predict TDS, including scores by other respondents as independent variables

Dependent variable	**N**	**Predictors**[1,2]	**R^2**	**F**	**B**	**SE**	**t**	**Sig.**
*p*TDS	98	School Gender	0.10	5.48	-1.49 2.97	0.66 1.31	-2.28 2.27	0.025 0.026
*t*TDS	98	*s*TDS	0.08	7.73	0.36	0.13	2.78	0.007
*s*TDS	98	*t*TDS	0.08	7.73	0.21	0.07	2.78	0.007

[1] Predictors were school, gender, age and TDS as rated by other informants. Only significant variables are shown.
[2] Regressions were also run including interactive factors for school, gender and age. For *p*TDS, school (p=0.000) and the interaction school*age*gender (p=0.003) were significant (R^2 =0.14, p=0.001). Results were the same for *t*TDS and *s*TDS.

Logistic regression models were run to predict outcome in terms of normal versus other ratings for prosocial scores (residuals showed that linear regressions were not appropriate), demonstrating a strong correlation between scores given by teachers and parents (p=0.025).

Table 3.11. Logistic regressions to predict odds ratios (OR) of prosocial ratings

Outcome	**N**	**Predictors**[1]	**B**	**OR**	**95% CI**		**Sig.**
					Lower	Upper	
*t*PROSOC	98	*p*PROSOC	-0.26	0.77	0.61	0.97	0.025

[1] Predictor variables in the regression models were school, gender, age (including interactions), and prosocial scores as rated by other informants. Only significant variables are shown.

vii. How do total difficulties scores and prosocial scores co-vary?

There is a strong relationship between TDS and prosocial scores, particularly when rated by parent ($p<0.0001$). This is shown by linear regressions for variation in TDS in Table 3.12 and by logistic regression to predict normal versus borderline & abnormal prosocial scores in Table 3.13.

Table 3.12. Stepwise linear regressions to predict relationship between TDS and prosocial scores

Dependent variable	**N**	**Predictors**[1,2]	**R^2**	**F**	**B**	**SE**	**t**	**Sig.**
*p*TDS	98	*p*PROSOC	0.26	16.99	-1.54	0.30	-5.18	0.000
		School			-1.91	0.60	-3.20	0.002
*t*TDS	98	*t*PROSOC	0.10	10.92	-1.06	0.32	-3.30	0.001
*s*TDS	98	*s*PROSOC	0.12	6.71	-1.52	0.52	-2.91	0.005
		*t*PROSOC			-0.49	0.24	-2.02	0.046

[1] Predictors were school, gender, age and prosocial scores. Only significant variables are shown.
[2] Regressions were also run including interactive factors for school, gender and age with much the same results.

Table 3.13. Logistic regressions to predict odds ratios (OR) of prosocial scores

Outcome	**N**	**Predictors**[1]		**B**	**OR**	**95% CI**		**Sig.**
						Lower	Upper	
*p*PROSOC	98	Age*	Affluent	Baseline				0.003
		school	Orphaned	-0.003	1.00	0.80	1.24	
			Very poor	-0.90	0.41	0.001	218.25	
			Poor	-0.06	0.94	0.76	1.17	
		*p*TDS		0.35	1.42	1.11	1.82	0.000
		*t*TDS		0.23	1.26	1.02	1.54	0.009
*t*PROSOC	98	*t*TDS		0.09	1.09	1.02	1.17	0.013

[1] Predictor variables in the regression models were school, gender, age (including interactive factors) and TDS. Only significant variables are shown.

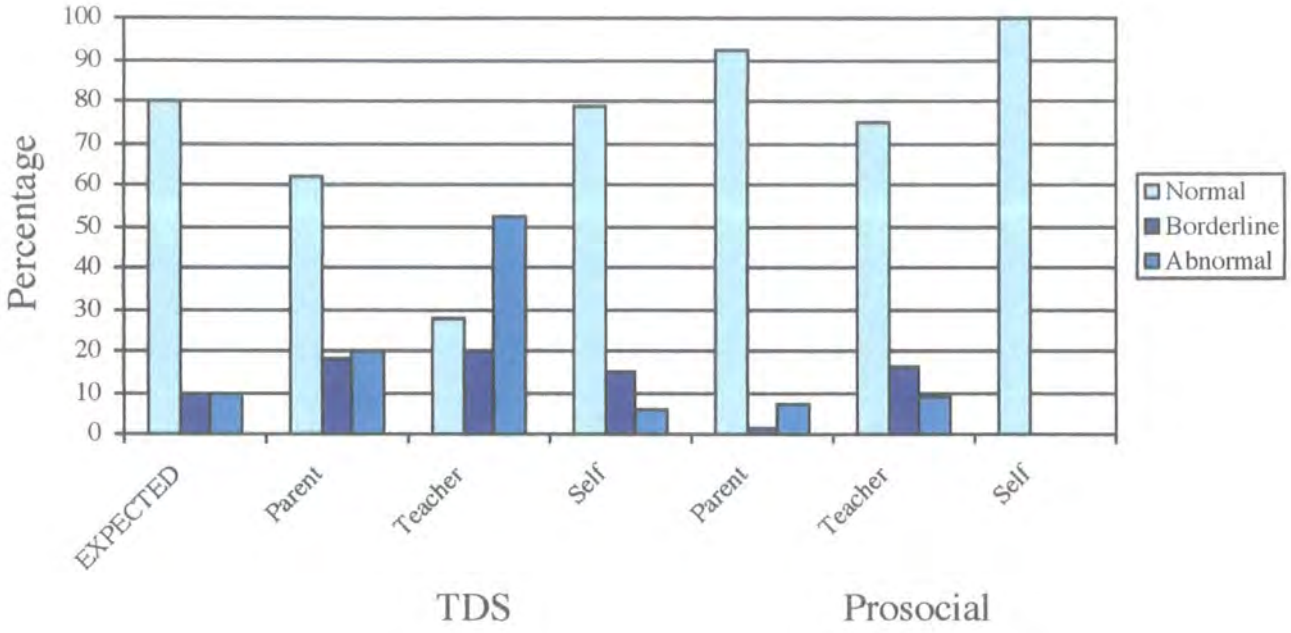
d. Comparison by type of informant for TDS and prosocial scores

i. Discrepancy in ratings

The proportion of children with abnormal total difficulties scores ranges from 6% to 52% depending upon the informant (Figure 3.5). The cut-off points suggested by Goodman (Goodman 1997, Goodman et al 1998) to demarcate normal versus abnormal scores for mental health problems have been chosen so that roughly 80% of individuals surveyed are rated normal, 10% are borderline and 10% are rated abnormal (see expected percentages in Figure 3.5). The 'worst' ratings for the Afghan sample are consistently given by the teachers, followed by the parents, while the children rate themselves as having much better mental health scores. For example, in the 'orphaned' school, none of the children rated themselves as having abnormal TDS scores but 65% were rated by teachers as falling within the abnormal range (Appendix 3.3).

Overall the prosocial scores are better than the total difficulties scores with far more children being rated as normal. Following the same pattern as above, the 'worst' prosocial ratings were given by teachers, followed by the parents, and the 'best' scores were given by the children themselves – they all rated themselves as normal (Appendix 3.3).

Figure 3.5. Proportion of sample children with mental health strengths and difficulties ratings by different informants, together with expected proportion



ii. Interrater correlations

Cross-informant correlations for parent, teacher and self-rated SDQ scores are presented in Table 3.14. Cross-informant correlations for a Brazilian study of 7 to 14 year olds (Fleitlich-Bilyk 2002) and for the British norm for 5 to 15 year olds (Goodman 2001) are also included for comparison. The Afghan teacher-self interrater correlation for the total difficulties scores is very significant (Spearman's rho, p=0.001). This shows that despite the large discrepancy between the teacher and self-rated mean and median TDS scores, when teachers rate the children highly, the children also rate themselves highly. The parent-self correlation is not strong (Pearson's correlation, p=0.076) and the teacher-parent correlation is weakest (Spearman's rho, p=0.803). Interestingly, the Afghan teacher-self correlation is much the same as those obtained from Brazil and Britain. The Afghan parent-self and teacher-parent correlations are much weaker than both these benchmark studies.

For the prosocial scores, there is a strong correlation between the parent and self-rated reports (Spearman's rho, p=0.001) indicating that when parents rate their children as having good prosocial scores, the children also rate themselves well. This strength of correlation is similar to that observed in the British study (no data were available for Brazil). The Afghan teacher-parent correlation approaches significance, while the teacher-self correlation is non-significant and much weaker than that reported for the British sample.

Table 3.14. Interrater correlations for strengths and difficulties scores

			N[1]	Pearson correlation		Spearman's rho	
				p	r	*p*	r
TDS[2,3]	Afghan sample	Parent-self	104	0.076	0.18	0.049*	0.19
		Teacher-self	121	0.003**	0.27	0.001**	0.29
		Teacher-parent	98	0.802	0.03	0.803	0.03
	Brazilian sample[4]	Parent-self	363	n/a	0.37	n/a	n/a
		Teacher-self	392	n/a	0.22	n/a	n/a
		Teacher-parent	736	n/a	0.30	n/a	n/a
	British norm[5]	Parent-self	3983	0.000***	0.48	0.000***	0.46
		Teacher-self	2767	0.000***	0.33	0.000***	0.29
		Teacher-parent	7313	0.000***	0.46	0.000***	0.42
Prosocial scores[2]	Afghan sample	Parent-self	104	0.011**	0.25	0.001**	0.33
		Teacher-self	121	0.713	0.03	0.440	-0.07
		Teacher-parent	98	0.051*	0.20	0.537	0.06
	British norm[5]	Parent-self	3983	0.000***	0.30	0.000***	0.30
		Teacher-self	2767	0.000***	0.23	0.000***	0.22
		Teacher-parent	7313	0.000***	0.25	0.000***	0.24

Significance levels: *$p<0.05$, **$p<0.01$, ***$p<0.001$

[1] Maximum sample sizes for interrater correlations to mirror data for British norm.

[2] For parent-self TDS data are normally distributed, so Pearson's correlation applies.
[3] For teacher TDS and all prosocial scores data are non-parametric, so Spearman's rho correlations apply.

[4] Fleitlich-Bilyk 2002
[5] Goodman 2001

e. Summary of findings

i. Prevalence of psychiatric disorder

22% of all sample children had a 'probable' psychiatric disorder (16% behavioural, 6% emotional, no cases of hyperkinetic disorders) (Table 3.4). This is double the norm for British children (11%) and compares to estimates of 13% for Brazil, 18% for Bangladesh and 27% for refugee children in the UK. A further 40 to 55% of children were 'possible' cases across all schools (Figure 3.2). Despite the criteria for their inclusion in the study (loss of at least one close relative), the 'orphaned' sample had the lowest prevalence rate of psychiatric disorders: only 15% were probable cases (Table 3.5).

ii. TDS and prosocial ratings (mostly normal)

The total difficulties scores for the Afghan sample are normal where rated by parents and the children themselves, and abnormal where rated by teachers. The teacher ratings are elevated in comparison to the norm for British children and refugee children in the UK (Table 3.7). The Afghan children have normal prosocial abilities, with scores remarkably similar to British counterparts and refugee children in the UK (Table 3.7).

iii. Variation in TDS scores

Children from the affluent school scored better than other children when rated by parent (p=0.026) and teacher (p=0.005, Table 3.9). Younger and older children were given worse ratings (Figure 3.4) when teacher-rated (p=0.007, Table 3.9). In further analyses,

girls had worse TDS than boys (p=0.026, Table 3.10) according to parents. None of these variables had an impact on prosocial scores.

iv. Comparing informants

Different informants are discrepant in their ratings. The 'worst' TDS and prosocial ratings are given by the teachers, followed by the parents, while the children themselves give much better ratings (Figure 3.5). Nonetheless, Afghan teacher-self interrater correlations are strong (p=0.001) and comparable to those obtained from Brazil and Britain (Table 3.14). For prosocial scores, the Afghan parent-self correlation was also strong (p=0.001) and comparable to the British study (Table 3.14).

Chapter 4

Contextual data and mental health

This section examines the relationship between mental health, displacement, family/peer relations, work activities, educational attainment and children's reported hopes for the future (see methods, Table 2.2 for full description of variables). More specifically, the following questions are asked: a) Do displacement and family/peer relations have an affect on mental health? b) Do working and non-working children differ in their mental health ratings? c) Do variables such as gender, age, displacement, family/peer relations or mental health predict children's educational scores? d) What are children's reported school or job aspirations?

The chapter concludes with a summary of findings.

a. Displacement and family/peer relations (N=115)

In order to examine the joint effect of displacement and family/peer relations on mental health, this section uses regression analyses for 115 children (90% of the total 128) for whom there were complete data on variables listed in Table 4.1. So few children have been excluded that it is not possible to calculate if they differ significantly from the remaining sample children.

Equal numbers of children born in Afghanistan and Peshawar are included in the sample (Table 4.1). More children from the 'very poor' (55%) and 'poor' schools (67%) were born in Peshawar than children from the 'affluent' (39%) and 'orphaned' (28%) schools, who were more likely to have been displaced from Afghanistan (p=0.029). Children from the 'very poor' and 'poor' schools have lived for an average of 11 years in Peshawar (this includes children born in Peshawar), compared to 9 years for children from the 'affluent' school and just 5 $^1/_2$ years for children from the 'orphaned' school (p=0.002). There were also significant differences in household size (p=0.008), presence/absence of father (p<0.0001) and extended family size (p<0.0001) across schools, and in presence/absence of father (p=0.001) across ages. Noticeably, children from the 'orphaned' school have smaller families than other children both in terms of household size and, in particular, extended family size. Only 5 (28%) of the 'orphaned' children lived with their fathers, and younger children were more likely to live with their fathers than older children. Number of friends does not differ by school or age, and there were no significant gender differences for either displacement or family/peer relations data.

Table 4.1. Displacement and family/peer characteristics of sample with percentages in brackets

			School				Gender[7]		Total
			Very poor	Poor	Affluent	Orphaned	Male	Female	
Displacement	Place of birth[1]	Peshawar	17(55)	22(67)	13(39)	5(28)	39(53)	18(44)	57(50)
		Afghanistan	14(45)	11(33)	20(61)	13(72)	35(47)	23(56)	58(50)
	Years in Peshawar[2]	Mean	10.5	10.6	8.2	7.0	9.6	8.9	9.3
		Median	11.0	11.0	9.0	5.5	11.0	11.0	11.0
		SD	2.9	2.2	4.0	4.0	3.4	3.8	3.5
Family/peer relations	Household size[3]	Mean	8.7	11.6	10.8	7.6	9.9	10.1	10.0
		Median	8.0	10.0	9.0	7.5	9.0	10.0	9.0
		SD	4.0	7.0	6.4	2.5	6.0	5.4	5.7
	Father living in household[4]	Yes	18(58)	29(88)	24(73)	5(28)	52(70)	24(59)	76(66)
		No	13(42)	4(12)	9(27)	13(72)	22(30)	17(42)	39(34)
	Extended family size[5]	Mean	13.6	23.4	20.6	8.4	17.4	18.0	17.6
		Median	13.0	17.0	18.0	9.0	13.0	16.0	14.0
		SD	9.0	16.1	16.0	4.4	15.4	11.7	14.1
	Friends[6]	Mean	2.4	2.6	2.4	2.6	2.7	2.1	2.5
		Median	2.0	2.0	2.0	2.5	2.0	2.0	2.0
		SD	1.8	2.1	2.4	1.7	2.2	1.9	2.1
N			31	33	33	18	74	41	115

[1] Pearson's X^2=8.99, 3df, p=0.029 for differences between schools
Kruskal-Wallis Test, X^2=15.10, 5df, p=0.010 for differences between ages
[2] Kruskal-Wallis Test, X^2=14.99, 3df, p=0.002 for differences between schools
Kruskal-Wallis Test, X^2=5.47, 5df, p=0.361, NS for differences between ages
[3] Kruskal-Wallis Test, X^2=11.86, 3df, p=0.008 for differences between schools
Kruskal-Wallis Test, X^2=9.46, 5df, p=0.092 NS for differences between ages
[4] Pearson's X^2=20.32, 3df, p<0.0001 for differences between schools
Kruskal-Wallis Test, X^2=21.27, 5df, p=0.001 for differences between ages
[5] Kruskal-Wallis Test, X^2=24.02, 3df, p<0.0001 for differences between schools
Kruskal-Wallis Test, X^2=8.41, 5df, p=0.135, NS for differences between ages
[6] Kruskal-Wallis Test, X^2=1.26, 3df, p=0.739 NS for differences between schools
Kruskal-Wallis Test, X^2=0.79, 5df, p=0.978, NS for differences between ages
[7] NS differences between genders for all variables

Neither displacement nor family/peer relations variables predicted the likelihood of psychiatric disorders in logistic regressions (results not tabulated).

There were no differences in mental health scores between those born in Peshawar and those born in Afghanistan. However, children resident in Peshawar for longer periods of time were more likely to be given abnormal *p*TDS than children with fewer years residence (p=0.006, Table 4.2). The analysis was repeated for children born in Afghanistan (N=58), but years in Peshawar did not remain significant for this smaller sub-sample (Figure 4.1).

Children who did not live with their fathers were almost 6 times more likely to be rated with abnormal *p*TDS (by their mother or another close relative) and *t*TDS (p<0.002, odds ratio OR in Table 4.2). This 'father effect' is also evident for the continuous TDS, with children living apart from their fathers receiving worse *p*TDS and *t*TDS (Figure 4.2). However, children living apart from their fathers did not rate themselves with worse TDS, on the contrary they had better scores (Figure 4.2). Children with large extended families rated themselves worse than those with fewer relatives (p=0.027, Table 4.2).

Table 4.2. Stepwise logistic regressions to predict abnormal TDS ratings from displacement and family/peer relations variables

Outcome[1]	**N**[2]	**Predictors**[3]		**B**	**OR**	**95% CI**		**Sig.**
						Lower	Upper	
*p*TDS	95	Yrs. in Peshawar	Yes	0.25 Baseline	1.28	1.05	1.57	0.006
		Father living in household	No	1.76	5.83	1.77	19.19	0.002
*f*TDS	109	Age		-0.65	0.52	0.36	0.75	0.000
		Father living in household	Yes No	Baseline 1.76	5.84	1.97	17.33	0.000
*s*TDS	114	Extended family size		0.04	1.05	1.01	1.09	0.027

[1] TDS scores dichotomised as normal & borderline vs. abnormal

[2] Regressions repeated for N=89 where full data are available for whole sample with much the same results (Appendix 4.1)

[3] Predictor variables were school, gender, age, place of birth, years in Peshawar, household size, father living in household, extended family size and number of friends. Only significant variables are shown.

Figure 4.1. *p*TDS by years in Peshawar for children born in Afghanistan & Peshawar

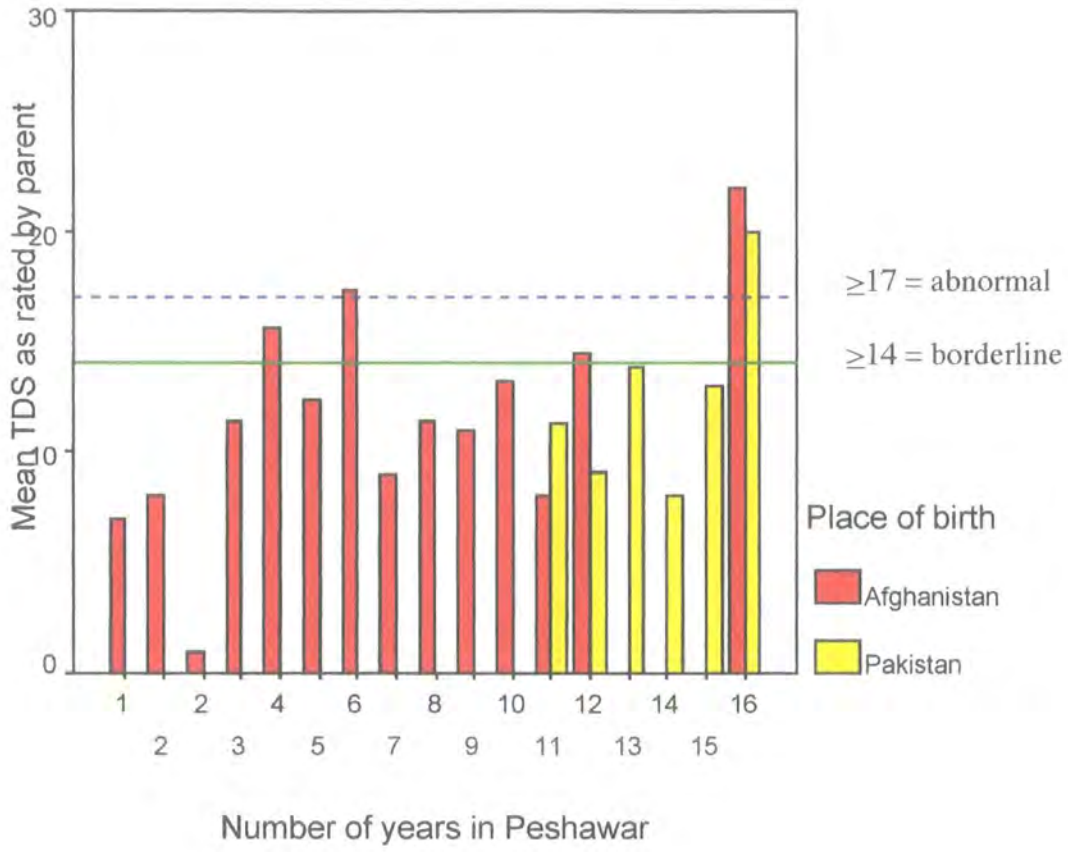
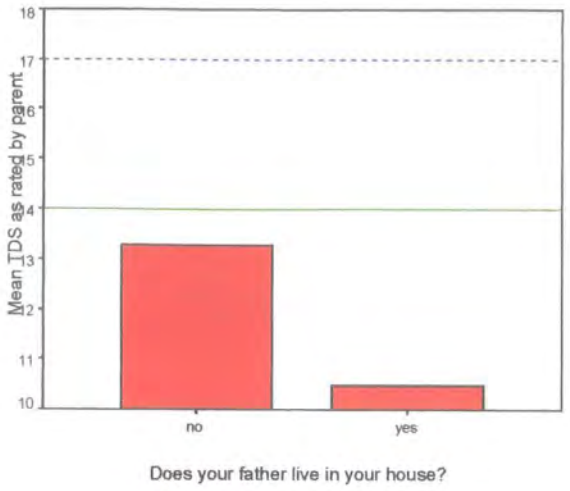
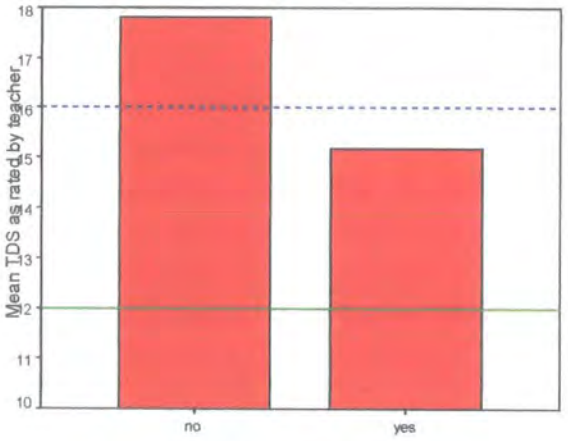


Figure 4.2. TDS as rated by different informants and presence/absence of father



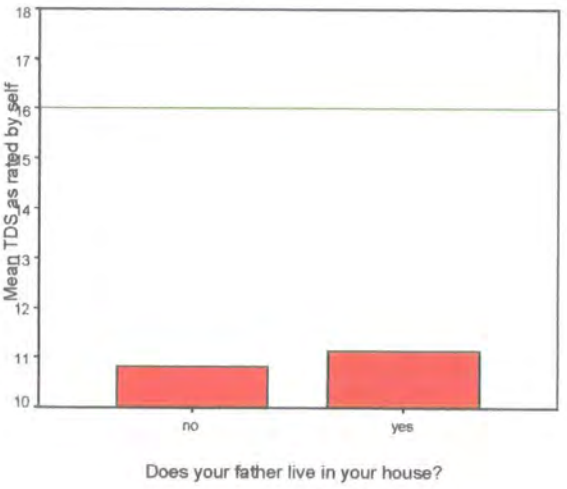
≥17=abnormal

≥14=borderline



≥16=abnormal

≥12=borderline



≥16=borderline

b. Working children: boys only (N=75)

Overall 26% of children worked. This included just 3 girls who were excluded for analyses in this section. Of the boys for whom work data was legible (N=75, Table 3.17), 30 (40%) worked in paid employment as well as attended school. Only 1 boy from the 'affluent' school worked. Although 54% of working boys were 'possible' or 'probable' cases for a psychiatric disorder, compared to 73% of non-working children, this difference is not statistically significant for this sub-sample (Table 4.3).

Table 4.3. School and mental health characteristics of sub-sample (N=75), with percentages in brackets

		Work (boys only)[1]		**Total**
		Yes	No	
School	Very poor	6(46)	7(54)	13(17)
	Poor	19(63)	11(37)	30(40)
	Affluent	1(5)	20(95)	21(28)
	Orphaned	4(36)	7(64)	11(15)
Likelihood of any disorder[2]	Unlikely	14(47)	12(27)	26(35)
	Possible	11(37)	22(49)	23(44)
	Probable	5(17)	11(24)	16(21)
Total		30(40)	45(60)	75

[1] Kruskal-Wallis Test X^2=0.88, 1df, p=0.347, NS for differences between ages
[2] Pearson's X^2=3.20, 2df, p=0.202, NS for differences in mental health ratings (unlikely vs. possible vs. probable)

Work per se has no impact on boys' mental health ratings regression analyses except where linked with age and school as an interactive factor (age*work*school, p=0.008), along with age (p=0.007) to predict likelihood of any disorder (N=75, unlikely vs. possible & probable ratings); and where linked with school (work*school, p=0.021) to

predict likelihood of emotional disorder (N=75, unlikely vs. possible & probable) (results not tabulated). No variables were significant for conduct or hyperkinetic disorders.

Again, in terms of TDS, work per se has no impact except where linked to age[11] and school as an interactive factor (p=0.003), along with age (p=0.000) to predict normal versus borderline & abnormal *t*TDS scores (results not tabulated). Work has no impact on prosocial scores (results not tabulated).

[11] Years displaced was not a significant factor in the regressions

c. Teacher-rated educational attainment (N=128)

Equal numbers of children obtained grades A (39%) and B (39%) in the sample (Table 4.4). Although more females than males obtained A's and B's, this difference falls short of statistical significance in X^2 analysis (p=0.077). Recall that classes are based on ability not age, and that boys and girls attend separate classes.

Table 4.4. Educational characteristics of sample (N=128), with percentages in brackets

		Educational score[2,3]			**Total**
		A	B	C	
Gender[1]	Male	30(37)	29(35)	23(28)	82
	Female	20(44)	21(46)	5(11)	46
Total		50(39)	50(39)	28(22)	128

[1] Pearson's X^2=5.13, 2df, p=0.077, NS for differences by gender (A vs. B vs. C)
[2] Pearson's X^2=7.10, 3df, p=0.069, NS for differences by school (A vs. B & C)
[3] Pearson's X^2=3.07, 2df, p=0.216, NS for differences between working & non-working children (A vs. B vs. C)

In order to find out which children receive the best and worst marks at school logistic regression analyses were used to predict educational scores dichotomised as 1) A versus B & C, and 2) A & B versus C (Table 4.5). Age was significant in predicting educational attainment where outcomes were dichotomised as A versus B & C (p=0.036) with older children being more likely to receive the best marks. Gender was significant (p=0.019) in predicting educational attainment where outcomes were dichotomised as A & B versus C, with boys three times more likely than girls to achieve grade C at school.

Table 4.5. Stepwise logistic regressions to explain variation in educational scores (N=128)

Outcome: educational score	**N**	**Predictors**[1]		**B**	**OR**	**95% CI**		**Sig.**
						Lower	Upper	
A vs. B&C[2]	128	Age		-0.27	0.76	0.59	0.99	0.036
A&B vs. C[3]	128	Gender						
			Girls	Baseline				
			Boys	1.16	3.20	1.12	9.10	0.019

[1] Predictors were school, gender, and age. Only significant variables are shown.
[2] When interactive factors are included, age (p=0.036) remains significant.
[3] When interactive factors are included, age*gender (p=0.018) is significant.

Displacement and family/peer relations variables were then added to the regressions (A vs. B&C and A&B vs. C) (N=115). Children with smaller extended families were more likely to receive grade As than children from very large families. Boys born in Afghanistan received the worst school marks. The significant variables were age (p=0.011), extended family size (p=0.029), gender*school (p=0.005) and gender*place of birth (p<0.0001) to predict educational scores (A vs. B&C) (results not tabulated; gender*place of birth (p=0.006) also predicted educational scores dichotomised as A&B vs. C).

In further analyses, mental health ratings based on triangulation between informants were added to the regression models (N=115, results not tabulated). Children rated 'possible' or 'probable' cases for psychiatric disorders were more likely to get the worst marks at school. The significant variables were gender*place of birth (p=0.005) and likelihood of

any disorder (p=0.025) to predict educational scores (A&B vs. C) (mental health ratings were not significant for A vs. B&C).

The final step was to add mental health scores as rated by different informants to the regression models (N=89, results not tabulated). Children rated 'unlikely' cases for emotional disorders gained the best marks at school, whereas children rated with worse peer relationships scores by their parents gained the best marks at school. The significant variables were gender*place of birth (p=0.008), likelihood of emotional disorder (p=0.024) and pPEER (p=0.001) to predict educational scores (A vs. B&C, no variables were significant for A&B vs. C).

d. Children's educational and job aspirations (N=119)

As part of the study children were asked what they wanted to do in the future. All the children (for whom data were legible, N=119) stated that they wished either to complete or continue their education (45%) or to seek employment in a specific job (56%) such as teaching, engineering, or medicine (Table 4.6).

Table 4.6. Education and job aspirations of sub-sample (N=119), with percentages in brackets

		School[1]				**Gender**[2]		**Total**
		Very poor	Poor	Affluent	Orphaned	Male	Female	
Future aspirations	Education	12(38)	17(55)	16(43)	8(42)	36(48)	17(39)	53(45)
	Job	20(63)	14(45)	21(57)	11(58)	39(52)	27(61)	66(56)
N		32	31	37	19	75	44	119

[1] Pearson's X^2=2.04, 3df, p=0.563, NS for differences by school
[2] Pearson's X^2=0.98, 1df, p=0.321, NS for differences by gender

One way of looking at these data is to differentiate between 'educational' aspirations (children who wanted to complete or continue their education, but did not know which career they wanted to pursue) and 'job' aspirations (children who knew which career they wanted to pursue). School, gender and age had no impact on children's aspirations in logistic regression analyses where these were the only variables included in the model (N=119, results not tabulated).

Analyses then explored whether displacement or family/peer relations had an impact on aspirations (logistic regression model, N=108). Children born in Afghanistan were more

likely to specify a job than those born in Peshawar, and children with larger extended families were more likely to specify a job; the significant variables were age*gender*school (p=0.011), place of birth (p=0.036) and extended family size (p=0.002).

Mental health ratings based on triangulation between informants had no impact on children's reported aspirations (N=108).

The last step was to evaluate whether future aspirations were related to mental health scores (using complete datasets with ratings from all 3 informants, N=84). Children's aspirations were associated to their peer relationship abilities. Thus, children rated with worse peer problems by their teachers were more likely to specify a job, whereas children who rated themselves with worse problems were more likely to state an educational goal. The significant variables were age*gender*school (p<0.0001), place of birth (p=0.004), extended family size (p<0.0001), *t*PEER (p=0.010) and *s*PEER (p<0.0001).

e. Summary of findings

i. Overview of predicted disorders

Place of birth/years in Peshawar and family/peer relations variables had no impact on predictions of 'probable' and 'possible' psychiatric caseness.

ii. 'Father effect' and extended family for TDS

The research picked up an interesting 'father effect' for this sample. Children whose fathers were not at home were 6 times more likely to receive abnormal *p*TDS and *t*TDS ratings ($p<0.002$, Table 4.2), as compared to those whose fathers lived at home (Figure 3.7). However, where children rated themselves, it was not 'father effect' that was significant, but the size of the extended family (i.e., 'how many more relatives do you have?' $p=0.027$, Table 4.2). Indeed, the extended family can be huge (median 14 people, ranging up to 85). For these children, it is not the presence or absence of their father that matters for *s*TDS, but how many more relatives are known. Children with large extended families rated themselves worse than those with fewer relatives (Table 4.2).

iii. Years residing in Peshawar

Children born in Afghanistan and Peshawar did not differ in their mental health scores. Another way of looking at the impact of displacement is to consider the number of years residing in Peshawar (this is equal to age for the children born in Peshawar and ranges from 1 year to 16 years for refugee children born in Afghanistan, some of whom came as babies). Even after taking into account 'father-effect', years resident in Peshawar was

associated with *p*TDS. (Thus children who had lived longest in Peshawar were more likely to be given 'abnormal' *p*TDS ratings than those who had relocated most recently (p=0.006, Table 4.2).

iv. Working boys

40% of boys worked as well as attended school. There is no impact of work per se on mental health for boys except where linked to age and school.

v. Gender differences

The two big differences between boys and girls show up in employment and education. Only 3 girls worked. Girls were 3 times more likely than boys to achieve the best marks at school (Table 4.5).

vi. Education

Children's educational scores were linked with a number of variables. Older children were more likely to receive the best marks (p=0.036) and boys were 3 times more likely than girls to achieve the worst marks at school (p=0.019, Table 4.5). There were also associations with displacement and family relations: boys born in Afghanistan received the worst marks and children with small extended families received the best marks. Children rated 'possible' or 'probable' cases were more likely to receive grade Cs at school (p=0.025), whereas children rated by their parents with worse peer problems scores gained the best marks at school (p=0.001).

vii. Prosocial behaviour

No variables were significant in predicting prosocial scores.

viii. Aspirations

When prompted about their aspirations, all the children reported that they wished to complete/continue their education or seek employment in a specific profession such as teaching, engineering, or medicine (Table 4.6). Children born in Afghanistan (p=0.036) and children with large extended families (p=0.002) were most likely to specify a job. Children's aspirations were associated to their peer relationship abilities: children rated with worse peer problems by their teachers were more likely to specify a job (p=0.010), whereas children who rated themselves with worse problems were more likely to state an educational goal (p<0.0001).

Chapter 5

Qualitative results

This section presents results on qualitative research undertaken using semi-structured interviews in Pashto (N=22) and projective techniques (12 drawings selected for this thesis). The sample was small and opportunistically selected by the school teachers. Female field assistants conducted interviews with 10 boys and 10 girls aged 11 to 16 from the 'poor', 'very poor' and 'orphaned' school samples. The responses to these interview questions were generally quite brief and did not yield the richness of information hoped for, with girls elaborating more on their answers than boys. The male project co-ordinator, Dr. A.W.H. Wardak, conducted interviews with the headmasters from the 'poor' and 'orphaned' school samples (example questions are reproduced in Appendix 2.3). The boys and girls from the 'poor' school were each asked to draw two pictures: 'as I see myself now' and 'as I see myself in the future'.

The interviews, along with the children's drawings, will be used to illustrate the following emerging themes of refugee children's lives in Peshawar: a) good and bad aspects of life in Peshawar; b) strong sense of identity; c) faith; d) social support mechanisms; and e) positive outlook for the future. Where relevant, comparisons will be drawn with 'The Children of Kabul' report (de Berry et al 2003), children in Northern Afghanistan (Loughry et al 2004, draft publication), Afghan refugees in NWFP (Wardak 1993), and internally displaced persons (IDPs) in Kabul (Arntson 2001). Studies of youth in Palestine (Baker 1990, Barber 1999, Chatty & Hundt 2001, Nashef 1992, Qouta

et al 1995a & 1995b, Thabet et al 2004) and Israel (Punamäki 1996) are also included. The overall aim of this section is to produce contextual information about how children view their lives in Peshawar.

a. Good and bad aspects of life in Peshawar

Children and teachers were very concerned about day-to-day problems of life in Pakistan such as economic problems, having to live in rented accommodation, inhospitable weather and dust (i.e. temperatures over 40°C, humidity around 80%), insects, and burdensome household duties. Children also reported harsh treatment from the Pakistani police.

Q. What things don't you like about Peshawar?

"Our poor Afghans sell potatoes and onions on their trolleys at the roadside. When the police come, they push them away and sometimes the police throw their vegetables into the canal. Whatever living they make is spoilt by police action. The other things that I don't like are the weather which is very hot, and the insects."

(refugee girl, aged 15)

"Life in exile is very bad... Afghan people live in very bad conditions in Pakistan. They live without house, proper clothes, food or job. Their children do not study. They work for little money to help their families... Our people are very talented; however, due to the lack of facilities they achieve very little. If conditions were favourable for them, their talent would flourish and they could achieve a lot more."

(Headmaster, 'orphaned' school)

The relocation of NGO services for refugees from Pakistan to Afghanistan and the resulting hardships for those who choose to remain in Pakistan was remarked upon by one of the headmasters.

Q. What kind of local services are available to refugees?

"In the past the international community provided different kinds of help for refugees such as healthcare, education and social welfare. These services have been shifted to Afghanistan. As a result refugees are facing a lot more difficulties."

(Headmaster, 'poor' school)

Children also highlighted positive aspects of life in Peshawar. These were primarily associated with a high economic standard of living, and included electricity, water, gas, transport and schooling.

Q. What kinds of things do you like about living in Peshawar?

"The things I like in Peshawar are water, electricity, gas, good schools, good courses, good transport and good cars."

(refugee girl, aged 14)

Q. Do you like living in Peshawar?

"I like living in Peshawar and I dislike it at the same time. I like it because there are good people. Gas and transport are good. It is good for travelling. We have water and power. I dislike it because the weather is bad and the Pakistani people tease us. They call us 'refugees', therefore I dislike it."

(refugee girl, aged 15)

Despite the harsh living conditions in Peshawar, children and their teachers also acknowledged that lack of security and services discouraged them from returning to Afghanistan. Indeed, this is picked up in another study by David Turton and Peter Marsden (2002:53) who cite fears about security and lack of employment opportunities as the most common reasons given by Afghan refugees for not wishing to repatriate.

Q. Do you like living in Peshawar?

"I don't like living in Peshawar, but we have no choice. Every Afghan wants to live in his country. However, because the conditions are not good in our homeland, we have to live here."

(refugee girl, aged 14)

Q. What factors discourage refugees from returning to Afghanistan?

"Factors which discourage refugees to return home are lack of security and lack of proper government. Some Mujahideen do not go back for ideological reasons. For instance, they left their homeland because Russia occupied Afghanistan in the 1980s; now they see America in the same way. Destruction of houses, lack of education and other services are other factors which prevent the return of refugees to Afghanistan."

(Headmaster, 'poor' school)

Children's concern with the hardships of day-to-day life in Peshawar is echoed in other studies of war-affected communities. Children in Kabul (de Berry et al 2003) worry

about their present situation as opposed to being overcome with memories of past suffering and fighting that took place several years ago. The past is experienced more in the way that it impacts children's current surroundings, relationships and well-being. Indeed, children living in Kabul cited traffic, ghosts in destroyed houses and landmines to be the biggest physical dangers. Dawn Chatty and Gillian Hundt (2001) have studied the affects of prolonged conflict and forced migration on Palestinian children and adolescents in the Middle East region (Lebanon, Syria, Jordan and Palestine) using qualitative research methodology including participatory tools such as village time lines, group discussions in homes and schools, and semi-structured interviews and life histories with key informants. Palestinian families were also concerned with immediate problems such as poor living conditions in refugee camps, unemployment and dirty water (2001:18-19).

b. Strong sense of identity

Afghan refugees in Pakistan maintain a strong sense of community (Wardak, personal communication) and children in this sample identified very strongly with Afghanistan. A salient example of national identity is illustrated in Figure 5.1, a drawing of a girl as she saw herself in the present, unhappy as a refugee in Pakistan, and as she saw herself in the future, holding the Afghan flag with the words 'free Afghanistan' written above. In a study of Palestinian refugee children, Yousef Nashef (1992) interpreted the appearance of the Palestinian flag in the vast majority of drawings as "a symbol of power, solidarity and a revolutionary redeeming collective psychology". The presence of flags, as well as the use of religious and national slogans, suggests that these have become a prominent part of children's personal identity (1992:162-163).

In the interviews, all of the children were able to name the current presidents of Afghanistan and Pakistan, indicating a degree of political awareness. Boys and girls stated that they wanted Afghanistan to be free and hoped one day to return home. According to Wali Wardak, an Afghan psychologist who has researched the affects of war trauma and displacement on Afghan refugees living in NWFP and fieldwork manager on this project, separation from homeland is tragic for Afghans who traditionally have a special love and affection for their 'fatherland' (1993:350). The homeland is a place of 'ancestors, honour and historical pride from which they ruled the area for centuries' (1993:361).

Figure 5.1. Self-representations: 'now and in the future' (reproduced with permission)

'As I see myself now'

'As I see myself in the future'

Q. When do you feel happy?

"I feel happy when I see my parents and family feeling happy, and when I see my country is free and its people are united."

Q. What do you think about life in Afghanistan and Pakistan?

"...no Afghan wants to live in Pakistan, or to live in another people's land. We want to live in our own country."

(refugee girl, aged 14)

Q. What do you think about life in Afghanistan and Pakistan?

"...I want my country to be free, to go home. We have no houses of our own; we live in rented houses. We don't like this. We do not own land. What can we do? We are here out of necessity. What can we do? When my country is free, I want to return to it."

(refugee girl, aged 11)

This sense of Afghan identity is often experienced in opposition to the local Pakistani population (i.e. ethnically non-Afghan), and children and teachers reported hostile treatment from the Pakistani government and local population. Children frequently referred to being called 'refugee' as one of the bad aspects of living in Peshawar. The generic Arabic word for refugee, *muhajir* (s.)/*muhajarin* (pl.) is used in a derogatory sense by some Pakistanis to describe Afghan refugees. According to Wali Wardak, Afghan refugees feel 'humiliated, degraded and dehumanised' (1993:352) as a consequence of being forced to seek refuge and aid in a land that they historically ruled. 'Afghans are a very proud and independent people with high self-esteem and a glorious past' (1993:359). Wardak identifies minority status, being regarded as intruders and used as scapegoats as factors adding to the stress of Afghan refugees (1993:350-351).

Q. What do you think about life in Afghanistan and Pakistan? Which one is better?

"The life of a Pakistani is better, because even if he or she is poor, they live with their dignity and pride. Our Afghans, no matter how wealthy we may become, have the stigma of being a refugee."

(refugee girl, aged 15)

Q. What things don't you like in Peshawar?

"I dislike the fact that we are living here when we fight with the Pakistanis. Although we don't want to have a problem with them, they constantly test by saying 'you are refugees, you are living in our country, go home'."

(refugee girl, aged 11)

Ethnicity has an important part to play in the relationship between the local Pakistani population and Afghan refugees. The Pakistani anthropologist, Akbar Ahmed (1986, cited in Centlivres & Centlivres-Demont 1988), has drawn attention to the fact that the majority of refugees in Pakistan are Afghan Pushtuns who have sought asylum in a tribal Pushtun territory in Pakistan, where they would be beneficiaries of traditional hospitality dictated by the pushtunwali code of honour practiced by the Pashtuns.

Q. Which refugees get on well with the locals?

"The people of NWFP are Pushtun and obviously they get on well with the Pushtuns of Afghanistan, but this does not mean that they do not have good relations with other ethnic groups from Afghanistan. At the beginning of the Afghan migration people of NWFP showed equal sympathy to all ethnic groups from Afghanistan. However, following the atrocities committed against the Pushtun in the North of Afghanistan by the Northern Alliance, the attitudes of the local Pushtuns became negative towards the Tajik, Hazara and Uzbek refugees."

(Head teacher, 'poor' school)

Historical and political events have seldom been studied as factors influencing children's well-being (Qouta et al 1995b:1197). Several studies in Palestine have however linked political identity and the meaning young people assign to trauma with psychosocial outcome. Brian Barber (1999) interviewed Palestinian adolescents and their families to explore the impact of social context of fighting and occupation. Barber found that Gazan adolescents demonstrated remarkable willingness and capability in participating in the political resistance to occupation. Over 80% of adolescents had participated in demonstrations, stone throwing, and in delivering supplies or assisting others. This level of activity occurred in the context of significant trauma that either triggered their activism or was a consequence of it. Despite substantial and prolonged risk and trauma, these adolescents were functioning well in the sense that they maintained strong family, educational and religious values. Barber found that participation in resistance 'facilitated and energised' strongly held and taught values and ideologies that are shared across generations: political values of equity and social justice, religious values of harmony and equality, and family and cultural values of unity, loyalty, deference and respect for legitimate authority.

Another study of Palestinian children by Ahmad Baker (1990) linked the 1987 Intifada ('uprising') with the mental health of Palestinian children. According to Baker, exposure to political and military violence is associated with the onset of conduct and psychological problems, although active participation in the conflict may also enhance self-esteem and shield children from developing psychological symptoms. Children who

actively engage in the Intifada tend to perceive themselves in a powerful role because they fight the Israeli army, and social support and high esteem are transmitted to them by adults and peers for their 'bravery'. According to Baker, "How individuals are perceived by their peers within the context of such conflicts, in conjunction with self-perceptions of their own ability to influence the course of the conflict, seems to be crucial in determining the extent to which they can protect themselves from the adverse effects of stress" (1990:504). Raija-Leena Punamäki (1996) studied the role of ideological commitment (in terms of glorification of war, patriotic involvement and defiant attitudes towards the enemy) for the mental health of Israeli children. He found that exposure to political hardships did not increase the presence of symptoms and anxiety, and depression and feelings of failure among children who showed strong ideological commitment; whereas among children with weak ideological commitment, exposure increased these symptoms.

Samir Qouta, Raija-Leena Punamäki and Eyad el Sarraj (1995a) have also studied Palestinian children during the Intifada, showing that traumatic experience, such as loss of family members, night raids upon homes and personal injury brought on psychological suffering through increasing neuroticism and some problems in cognitive performances. A follow-up study (Qouta et al 1995b) approached the issue of Palestinian children's well-being from a different angle, by examining the impact of the Israeli-Palestinian peace treaty, and the way children responded influenced their psychological well-being. According to Qouta et al, children suffered less neuroticism after the peace treaty than before. Furthermore, those who welcomed the treaty by participating in the celebrations

suffered less from neuroticism and enjoyed better self-esteem than those who did not participate. The implication is that the peace treaty had a psychologically positive effect only on children who supported it and expressed their political opinion by joining in the festivities. The authors suggest that the opportunity to ventilate feelings, express nationalistic affiliation, and the feeling of reaching one's political goals in combination might explain the decrease in neuroticism because of the peace treaty: "Apparently, after the cessation of hostilities the politically active children felt that their sacrifices in the Intifada struggle contributed to a beneficial social change that increased their self-esteem" (1995b:1206).

Dawn Chatty and Gillian Hundt (2001) also studied political awareness and activism among Palestinian youth. They consider active participation in political events as a form of coping, giving youth a sense of hope, if not choice in determining their future (2001:28). As in this sample of Afghan children, Palestinian refugees in Lebanon felt discriminated against by the host community (2001:17), and in Gaza children's perceptions of being a refugee meant being humiliated, displaced, homeless, deprived and inferior (2001:18). There were differing opinions concerning the issue of returning to Palestine. In contrast to Afghan refugees in this study, some Palestinian children expressed the wish to stay in the countries they had grown up in (2001:16).

In all the above studies, young people appear to be politically aware and motivated. Palestinian youth hold strong political, religious, family and cultural values which form part of a wider Palestinian identity, helping them to give meaning to their current

situation and also to look towards the future. The meaning that young people in Palestine assign suffering and their ability to participate both in political resistance and festivities is important for their mental health. Afghan children in this study also reported strong ideological commitment, and although they were not involved in the same kind of activism as Palestinian youth, they stated that they wanted to participate in rebuilding their country and helping their fellow countrymen, and they saw their education as a means to achieving their goals. This sense of collective identity, together with the desire to be a part of making things better for the future appears to have a positive influence on their well-being. Children's expressions of national pride, religious commitment and strong family values should however be accepted with some caution in the context of a society which places children under strict family, religious and social control (Wardak, personal communication).

Surprisingly, there were no gender differences in the content of these interviews with Afghan children. The only obvious gender differences were in clothing and in the inclusion of plants and flowers in the girls' drawings. Girls in this study attended school so were not confined to the house; whereas adolescent girls in Kabul (de Berry et al 2003) talked frequently about their frustration over restrictions placed on their movements and opportunities, particularly the loss of education. Girls were also worried about their security, other's perceptions of their *tarbia* (page 24, introduction), and problems associated with marriage such as moving away from their family. Furthermore, girls thought that they were more likely to develop negative feelings than boys because they are more likely to have time to reflect on their problems, as they were often confined

to the house (2003:56). Dawn Chatty and Gillian Hundt (2001) also reported gender differences among Palestinian youth including heavy workload, reduced educational opportunities and lack of freedom of movement for girls (2001:28).

Figure 5.2. Pupils at Mariam School ('poor' school) (reproduced with permission)

c. Faith

It is clear that Afghan refugees have maintained strong religious values in Pakistan. Prayer is a central part of children's lives and was mentioned at least once by all the children when they were asked to describe a typical day. One girl made a very specific reference to Islam, stating that she wanted to become '*Hafiz*' of the Holy Qur'an (to memorise it), while others made more general references to Allah in relation to peace. The frequency with which religious references appear in the interviews suggest that Islam is an important part of children's identity. 'The Children of Kabul' (de Berry et al 2003) report maintains that religious faith is considered good for children's well-being, and that children who can recite the Qur'an are particularly praised (2003:10).

Q. What do you want to be in the future?

"It is my wish and the wish of my mother to become Hafiz of the Holy Qur'an. I have already memorised eleven chapters. I want to complete it and become Hafiz. Subsequent to that I want to become a doctor and serve my country and others."

(refugee girl, aged 15)

Q. What kind of impact did the war have on you?

"I always prayed to Allah to bring peace and tranquillity to our country and to make it a developed country like other developed countries, and the region of Islam to always be there."

(refugee girl, aged 15)

Q. What kind of impact did the war have on you?

"I was personally very sad. I prayed and said 'O, Allah stop the war. If the war does not stop, I will suffer from this and be sad."

(refugee girl, aged 11)

One of the boys depicted himself in the future with a beard, skullcap, shoes and clothing typical of a religious scholar or leader (Figure 5.3). He is holding what appear to be religious scriptures.

According to the headmaster of the 'poor' school Afghan refugees are under pressure from the Pakistani government to follow their Pakistani religious traditions.

"In religious affairs we follow Saudi Arabia... However, the Pakistani government pressurises the Afghan refugees time and again to follow Pakistani traditions. The refugees do not do this."

(Headmaster, 'poor' school)

Figure 5.3. Self-representations: 'now and in the future' (reproduced with permission)

'As I see myself now'

نوم: عبدصبور
ولد: محمد آصف
صنف: شپږم

Name Abdul Saboor Son
of Mohammad Aasef

Class 6
Age 12

اوس

Now

'As I see myself in the future'

آینده

Future

Islam has also been identified as important for children's coping in Northern Afghanistan (Loughry et al 2004, draft publication). Their project sought to investigate frequency of feelings, thoughts or behaviour associated with psychosocial well-being as defined by de Berry et al's 'The Children of Kabul' (2003) report. It was hypothesised that the higher the level of the child's well-being, the more sophisticated problem-solving strategies they would employ. However, local focus-group participants rated 'pray to God for help' as the most successful and desirable coping strategy above other strategies such as 'talk to other children about the problem' and 'think about the problem and solve it for themselves'. Similarly, Abdel Aziz Thabet, Victoria Tischler and Panos Vostanis' (2004) study 'Maltreatment and coping strategies among male adolescents living in the Gaza Strip' identified 'acceptance of faith in God' as the most successful coping strategy, used almost all the time by 79% of sampled 15 to 19 year olds (2004:84).

d. Social support mechanisms

Not surprisingly, children identified their families and friends as sources of comfort and support in times of difficulty. It is also clear that children also do what they can to help their relatives and friends. Wali Wardak (1993) has pointed out that distinguishing features of Afghan society including family structure and social networks are damaged at a time when they are most needed (1993:351).

Q. When you feel scared, is there anybody to help you?

"When I am unhappy or scared, my mother comes to my help. When I have nightmare, my mother will come, give me some water, then comforts me. When I feel sad my mother will comfort me."

Q. What kind of help do you offer your family?

"If I become a doctor or an engineer, I will help my family; I will care for their feelings. Whatever they tell me to do, I will do it because I owe a great deal to my family. My family wants me to learn and get an education."

(refugee girl, aged 15)

Q. When you feel scared, is there anybody to help you?

"When I get upset or scared during day or night, my mother comes to me. First she gives me water to drink or something else, in order to make me feel happy. Then she assures me by saying 'don't feel sad, we will go home'."

(refugee girl, aged 11)

Q. Do you help your friends?

"When I come to school with my friends, and they do not have books or notebooks, I help them. Similarly, when they face a problem, I help them... For my success in life, it is essential to help my country, friends, tribe and relatives. I should get my education and help them."

(refugee girl, aged 11

'The Children of Kabul' report (de Berry et al 2003) also stressed the importance of the family in helping children to secure well-being and happiness, and in overcoming social and emotional problems. Neighbours, teachers, mullahs and friends are also influential. However, it is not enough to merely have people around, children in Kabul need positive relationships which include advice and encouragement, care and protection, training and discipline, and love. Encouragement and support children receive from the people around them are crucial for their resiliency, and being able to share suffering with others is essential in enabling children to cope with difficulties. Family relations are not always supportive: children identified family loss, separation, tensions, and work and economic responsibilities as causes of concern. Likewise, family support and solidarity enable Palestinian families to buffer and protect each other from the effects of poverty, unemployment, political instability and illness in the Middle East (Chatty & Hundt 2001:23).

Children in Peshawar displayed remarkable empathy and understanding of other people's needs and feelings.

Q. When do you feel happy and when do you feel sad?

"I feel happy when I see my parents and family feeling happy, and when I see my country is free and its people are united. When I see my parents are feeling sad, and there is war in our country or elsewhere, I feel upset."

Q. Do you help your friends?

"I help my friends and classmates in all sorts of problems they face. I also participate in their joys and sorrows."

(refugee girl, aged 14).

Q. When do you feel upset?

"When I see people in trouble or an old man who can't cross the road, or someone begging or someone being injured, I feel upset."

Q. Do you help your friends?

When my friends are in trouble, for example when they have problems with schoolwork, I will help them. I never ever want my friends to be upset with me. Here we are in exile: I never want the day to come when my friend goes to his region and I go to my region, and my friend has bad memories of me."

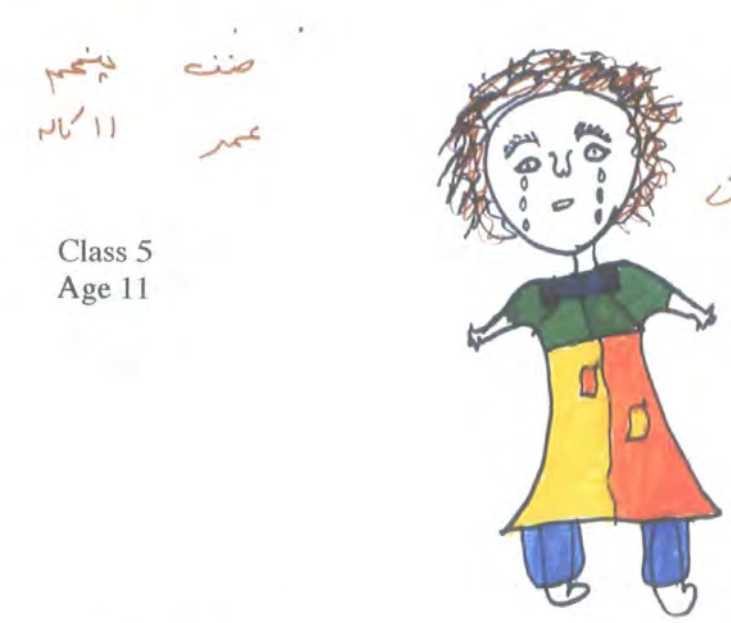
(refugee girl, aged 15)

e. Positive future outlook

The drawings collected show that children had an optimistic attitude towards the future. This is clearly evident when comparing self-representations 'as I see myself now' and 'as I see myself in the future' (Figures 5.1, 5.3–5.6). Whereas children in the present appear unhappy and in some cases crying, children pictured in the future are happy and smiling. In the present, several of the children are wearing tatty clothing and have messy hair compared to the future where they appear smart and have new clothes. Depictions of the future were also positive in a review of psychosocial support activities in a camp for internally displaced persons (IDPs) in Kabul (Arntson 2001). Another feature of the girl's drawings that jumps out at the viewer (also noted in the drawings of IDPs in Kabul) is the inclusion of flowers, plants and trees in the representations of the future (Figures 5.4 & 5.5), whereas none of the drawings depicting the present include plants. One girl has drawn herself crying and poor in the present, and happy in the future with a house and surrounding fields against the backdrop of mountains in Afghanistan (Figure 5.7).

Figure 5.4. Self-representations 'now and in the future' (reproduced with permission)

'As I see myself now'



Now

Class 5
Age 11

Name Salmaa

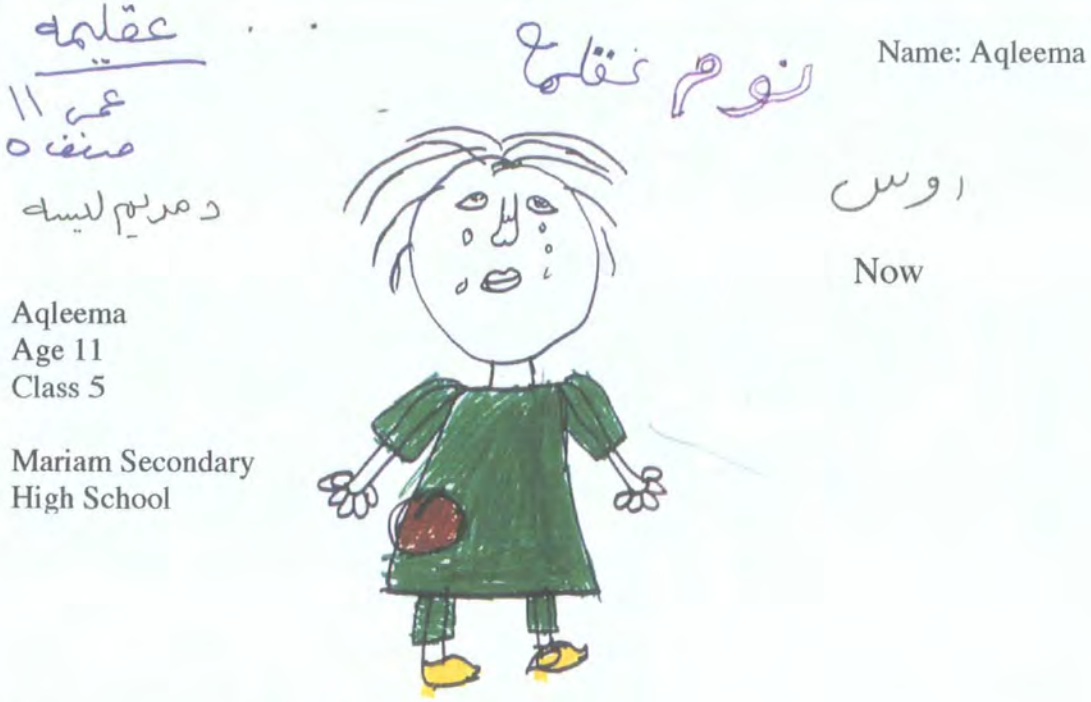
Father's name
Amanullah Nasrat

'As I see myself in the future'

Future

Figure 5.5. Self-representations: 'now and in the future' (reproduced with permission)

'As I see myself now'



'As I see myself in the future'

Figure 5.6. Self-representations: 'now and in the future' (reproduced with permission)

'As I see myself now'

Name Baher
Mujtabaa Son of
Mohammad Nader

Class 6
Age 13

اوس

Now

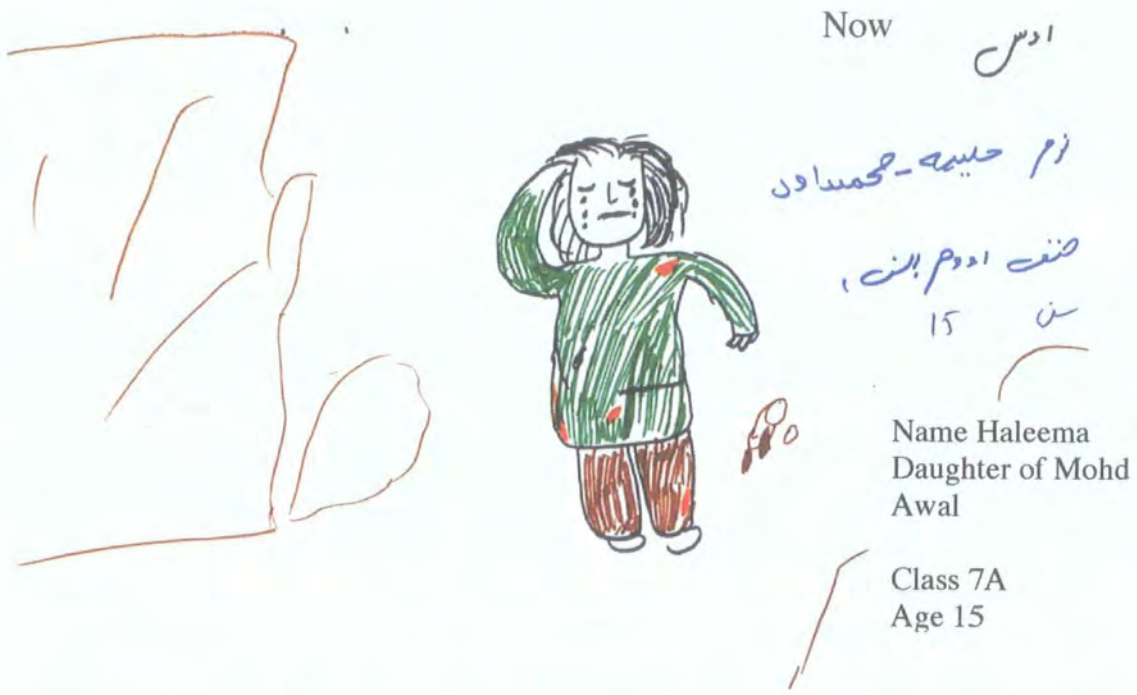
'As I see myself in the future'

آینده

Future

Figure 5.7. Self-representations: 'now and in the future' (reproduced with permission)

'As I see myself now'



'As I see myself in the future'

The interviews also revealed a positive outlook. None of the children mentioned negative things when they talked about the future. One of the most common aspirations that children mentioned was for 'peace and tranquillity' and to be able to return to Afghanistan. This phrase occurred at least once in all of the interviews, suggesting that values of peace and national pride are encouraged in children from an early age.

Q. Can you tell me when you are happy?

"I will feel happy when peace and tranquillity returns to my country."

(refugee boy, aged 16)

Q. What will help you achieve your ambitions?

"Just peace and tranquillity in my country."

(refugee girl, aged 11)

Education was clearly seen as a path toward building a better future. Children stated that they wanted to complete their education and pursue careers in medicine, teaching and engineering. War was recognised as an obstacle in achieving these aims because it denies children the opportunity to learn. This finding is echoed in the review of psychosocial work in Kabul (Arntson 2001), in a Save the Children project in Kabul (2001) and in 'The Children of Kabul' report (2003:24), which additionally points out that education plays an important part in children's well-being by helping them to learn respect and to develop good *tarbia*. Education is also seen as vitally important for

Palestinian children (Chatty & Hundt 2001) although unlike this sample of Afghan children, a growing perception of lack of job opportunities discouraged some adolescents from completing higher education (2001:27).

Q. How did war in Afghanistan affect your family?

"War affects our lives in several ways. We are left out of school; we are deprived of other courses and education in general. We are deprived of everything."

(refugee boy, aged 15)

Q. What kind of help do you offer your family?

"When I grow up and have obtained an education, I will get a job, then I will help my family and my fellow countrymen and women."

Q. What will help you achieve your ambitions?

"For my success in life, it is essential to help my country, friends, tribe and relatives. I should get my education and then help them."

(refugee girl, aged 11)

Afghan children reported that they wanted to be able to help family members and fellow countrymen, and to participate in the re-building of their country. This was also a major theme in the Save the Children (2001) project in Kabul. In this study, children's goals were overwhelmingly associated with helping others, with very little mention of self-

focused ambitions. Sundberg, Poole and Tyler (1983) studied 15 year-olds' time perspectives of future events in schools in Australia, America and India. They found that while Australian and American adolescents were very attentive to their own courtship, marriage and children, Indian adolescents were relatively more interested in the same events happening to others. One explanation may be that Western cultures are more self-orientated than some other cultures.

Q. What do you want to do in the future?

"It is my ambition to get as much education as possible, to serve my country and my people, and to care for the feelings of my fellow countrymen and women. If they are poorer to help them. If they have other problems to help them with their problems. I would like to care for the feelings of my parents."

(refugee girl, aged 15)

Q. What do you want to do in the future?

"When I finish school, I want to go to university and become a good person, a doctor, and help my people."

(refugee girl, aged 14)

Understanding children's hopes and expectations is important because they influence current behaviour and play an important part in identity formation (Nurmi 1991). Future orientation provides grounds for setting goals, planning and decision making, exploring

options and making commitments, and consequently guides the person's developmental course (Nurmi 1991, Seginer 2003, Sundberg et al 1983). Students who are optimistic and have a positive future outlook are more likely to be motivated to actively plan for the future than students who hold negative attitudes towards the future (Nurmi 1991). Rachel Seginer (2003) points out that future orientation has a special importance for individuals going through developmental and transitional periods in which they have to prepare themselves for what lies ahead. As such, it is especially important to understand refugee children's goals and perceptions of themselves in the future. Afghan children in this study report strikingly high aspirations which, given their present situation, may not be realistic. Although children's positive outlook might be considered beneficial for their present well-being, it could have negative repercussions in the future when on leaving school they are faced with a lack of opportunity to realise their goals.

Much research into future expectations has focused on the thematic aspects or the content of future orientation. Nurmi's (1991) review of 30 studies of adolescents' future orientation has revealed consistencies in the content of expectations cross-culturally, with adolescents from Anglo-American cultures focusing relatively more on goals related to leisure activities and personal happiness, adolescents with a high rate of urbanisation focusing relatively more on education and career goals, and adolescents from traditional societies focusing on family-related topics. Interestingly, in traditional societies such as India and Mexico, parents and family are more involved in the planning process than in Anglo-American cultures.

Nurmi's (1991) review of the literature reveals gender differences in adolescents' future expectations, with girls emphasising family-related expectations and boys emphasising educational and occupational goals. This was not the case in this study, with all the children stating that they wished to continue their education or seek employment in a specific profession such as teaching, engineering, or medicine. Gender appeared to have little detectable effect on self-reported educational and professional goals (see results). In these interviews, both boys and girls reported educational and professional goals, and both boys and girls wanted to be able to support their families and help other people. Sundberg et al (1983) also revealed gender differences in future time perspectives of Indian children but not Australian or American children: girls showed a shorter time perspective than boys in India. The traditional expectation was that a girl would have an arranged marriage early in her life, whereas boys were expected to have an occupation and marry later.

Chapter 6

Discussion

This study aimed to employ a multidisciplinary approach to study the mental health of Afghan refugee children. Quantitative data generated by a western clinical tool for screening mental health was complemented with contextual information yielded by anthropological research methods.

a. Childhood vulnerability

What factors impact on the mental health of Afghan refugee children? Family relations followed by displacement history had the strongest influence on the mental health scores of this sample of children. Thus, children whose fathers did not live at home were over 6 times more likely to be rated with mental health difficulties by both their teachers ($p<0.0001$) and their principal carers ($p=0.002$). Where children rated themselves, it was not the absence of their father but rather large extended family size ($p=0.027$) that had a negative impact on mental health. In terms of displacement adversity, children born in Afghanistan did not differ in their mental heath from those born in Peshawar; however, children who had relocated most recently in Peshawar had better mental health according to their parents than those who had resided there for longest ($p=0.006$).

Despite the criteria for their inclusion in the study, a purposive sample of children orphaned from one or more close relatives had a lower prevalence estimate for psychiatric disorders than randomly selected children from other schools. These

'orphaned' children were cared for by the remaining parent or other relatives within the family home. Indeed, these children came from relatively wealthy families (confirmed by an independent measure of affluence based on household amenities) and attended a private fee-paying school suggesting that they benefited from substantial family investment. Type of school per se, a marker for socio-economic status, made no strong impact on mental health ratings.

Surprisingly, gender made no detectable impact on mental health ratings. Girls are usually shown to have more emotional problems than boys, whereas boys tend to have more conduct problems (e.g. Simonoff et al 1997). Considering the markedly differentiated gender roles and expectations characteristic of Afghan society (Abrioux 1998), it is unexpected to find no salient differences in mental health ratings by gender. One explanation might be a selection bias whereby fewer girls than boys have the opportunity to attend school. It is possible that girls enrolled in education have better mental health than those confined to the home, meaning that girls in this sample would be more highly selected than boys. Age had no significant impact on mental health in this sample. Research suggests that as a general rule, younger children are more vulnerable than older children (Woodhead et al 2003). This may have been apparent for Afghan children if a wider age range had been included in the sample.

Open-ended interviews revealed comparable attitudes amongst boys and girls including a strong sense of Afghan identity, enthusiasm for education, and a high value placed on family and peer relationships. Girls elaborated more on their responses but this could be

the result of employing only female field assistants. The only striking gender differences in this study are that ten times as many boys as girls worked in paid employment as well as attended school, and boys were three times more likely to get the worst marks at school ($p=0.019$). These gender differences in work and educational attainment are expected findings. In the children's drawings, there were obvious gender differences in clothing and in the inclusion of plants and flowers in the girl's drawings.

b. Coping strengths and resilience

Qualitative data show that Afghan children experience substantial hardship living in Peshawar. Day-to-day problems include economic difficulties, harsh treatment from the Pakistani police and local population, and the stigma attached to being a refugee. Projective techniques showed the children to be unhappy, and in some cases crying in the present. However, children emphasised the importance of the family in dealing with problems and in providing comfort and support. It comes as no surprise then that adversity related to one of children's main coping resources, the family (i.e. the 'father-effect' and extended family size), has a strong impact on mental health.

Afghan refugee children reported a shared sense of community and identified strongly with Afghanistan. Family, religious and cultural values appear to give meaning to children's lives in Peshawar, as well as orientation towards the future. Children were committed to their families, fellow countrymen and their homeland, and stated that they wanted to participate in making things better for the future. These attitudes are likely to be good for children's well-being in the present, as indicated by high prosocial scores, empathy towards other people's needs and feelings and positive aspirations for the future. However, parents of children who have resided longest in Peshawar rated children with more mental health difficulties than those who had arrived most recently (p=0.006), suggesting that over time, lack of opportunity to realise such high aspirations in Peshawar will have a negative impact on mental health.

c. Usefulness of SDQ as a tool

This sample of Afghan refugee children had a high prevalence of psychiatric disorders with 22% being rated 'probable' cases and a further 46% rated 'possible' cases. The prevalence estimates for this Afghan sample can be compared to those of other studies employing the SDQ cross-culturally (the SDQ has been translated into over 50 languages). The studies included in Table 4.1 have been selected to include community as opposed to clinical samples, school children and refugee populations. Caseness rates for 'probable' and 'possible' diagnoses for Afghan children are double those predicted in a national survey of British children (Goodman, personal communication; based on data from Meltzer et al 2003). Studies of community samples of children living in Brazil (Fleitlich-Bilyk 2002) and Bangladesh (Mullick & Goodman 2001) estimated 13% and 18% of children, respectively, to have psychiatric disorders. Two studies of refugee children in the UK found disparate caseness rates ranging from 8% of refugee and migrant children attending a school in north London (Leavey et al 2004) to 27% of refugee children enrolled in six schools in Oxford (Fazel & Stein 2003).

Table 6.1. Summary of methodological and sample characteristics across studies

Study	**N**	**Sampling frame**	**Informant participation rate**			**Caseness cut-off points**		**Age range**	**Prevalence estimates**	
			Parent	Teacher	Self[1]	TDS	Impact		'Possible'	'Probable'
Afghan sample in Peshawar	128	School	82%	95%	99%	≥16	≥2	11-16	46.1%	21.9%
British norm[2] (Goodman 2003, personal communication)	4300	Child Benefit Records	100%	68%	93%	≥14	≥2	11-15	19.9%	10.8%
Refugee sample in the UK (Fazel & Stein 2003)	101	School	0%	100%	0%	≥14	≥2	5-18	N/A	27%
Refugee & migrant sample in the UK (Leavey et al 2004)	206	School	0%	0%	100%	Unclear	Unclear	11-16	N/A	8.4%
Bangladeshi sample (Mullick & Goodman 2001)	162	School	100%	100%	89%	[3]	≥2	4-16	N/A	17.9%
Brazilian sample (Fleitlich-Bilyk 2002)	1251[4]	School	[5]	[5]	[5]	Unclear	≥2	7-14	N/A	12.5%

[1] Percentages for self-report questionnaires apply to 11-16 year-olds only

[2] Based on data obtained for the '1999 British Child and Adolescent Mental Health Survey' (Meltzer et al 2003)

[3] Cut-off points for symptom scores were *p*EMOT ≥7, *p*COND ≥6, *p*HYP ≥8, *t*EMOT ≥6, *t*COND ≥6, *t*HYP ≥8, *s*EMOT ≥8, *s*COND ≥6, *s*HYP ≥7, with hyperactivity disorder predicted only when criteria met by ≥2 informants

[4] N=898 in Fleitlich & Goodman (2001) whereas this study uses figures from Fleitlich-Bilyk (2002) which gives more detailed results

[5] Data were collected from 2+ informants in 98% of cases and 3 informants in 47% of cases (2002:117), with unspecified information

The comparability of studies employing the SDQ is limited in terms of predictions based on varying diagnostic criteria and samples, and use of different informants (Table 4.1). Estimates of the prevalence of psychiatric morbidity depend on diagnostic systems. Cut-off points for demarcating 'normal' versus 'abnormal' symptom scores and the complexity of diagnostic criteria vary across studies. These different thresholds represent varying degrees of psychopathology and consequently limit the comparability of these prevalence estimates. Comparability of prevalence estimates is also limited by use of different sampling frames including school lists and Child Benefit Records, large range of sample sizes, and variation in age and gender composition of sample.

Significantly, choice of informant differs across studies. Estimates for a priori caseness for the Afghan sample are based on combined symptom and impact scores given by the children's parents and teachers: the adult informants are the ones who responded to the impact supplement in terms of the four-point severity scale required by the computerised algorithm for SDQ data. Children scored impact only in terms of a binary yes/no answer, which cannot contribute to the diagnosis of psychiatric caseness. The algorithm is designed to predict a 'probable' emotional or conduct disorder if at least one informant reports a combination of a high symptom score and resultant impact (Goodman et al 2000b:537). Prevalence estimates where data from one or more informants are missing are therefore likely to underestimate psychiatric morbidity.

Choice of informant has a strong impact on prevalence rates generated by the SDQ computerised algorithm, a significant point considering that it is not always practical or

financially viable to collect data from parents, teachers and children. The prevalence estimate for this sample was calculated to be just 5% based only on parent-reported symptom and impact scores (3% emotional and 2% conduct), and 22% based on both parent and teacher-reported scores (6% emotional and 16% conduct). As a worst case scenario, this rate would rise to a maximum of 23% based on ratings by all 3 informants (where all self-rated 'yes' responses to the perceived difficulties item were scored as impact of the highest severity). Estimates of psychiatric caseness for refugee school children in the UK range from 8% where based on self-ratings (Leavey et al 2004) to 27% where based on teacher-ratings (Fazel & Stein 2003).

Within child psychiatry it is well established that information from multiple informants is a better predictor of disorder than just one source (Meltzer et al 2003:19-20). Screening methods for child mental health problems have previously focused on parent and teacher-reports but more recently information has also been collected from the children themselves. Informants vary in the extent to which they report different types of disorder and SDQ predictions are likely to be more accurate when based on triangulation between multiple informants. Behavioural disorders may only be apparent in certain settings, for example severe conduct problems may be present at school but not at home. Hyperkinetic disorders are by convention diagnosed when there is evidence that symptoms are present in two or more settings, usually home and school (Goodman et al 2000a, 2000c). The predictive algorithm generates 'probable' ratings for hyperactivity disorders only if diagnostic criteria are met according to parents and teachers (Goodman et al 2000a:131).

Previous psychiatric analyses in Britain have shown teachers and parents to be more reliable informants of mental health status than children (Goodman et al 2000b). Goodman et al (2000b:236) found that for the British children retaining teacher-ratings detected more externalising disorders, while retaining parent ratings detected more internalising disorders. Afghan parents identified 4 emotional and 2 conduct cases, whereas the children's teachers identified 7 emotional and 21 conduct cases. Only one child rated by their parent as a 'probable' case for a disorder was rated in the same way by their teacher. Although the reliability of children's self-reports for mental health diagnosis questioned within child psychiatry (Fleitlich-Bilyk 2002:35), and self-report SDQs are less useful than either parent or teacher reports (Goodman et al 2000b:536), children can provide additional information about worries and anti-social behaviours that parents and teachers had not noticed or that had been hidden from them (Goodman et al 2000c:646). The main expense of omitting the self-ratings is missing some emotional disorders (Goodman et al 2000b:536).

In the Afghan context (Wardak, personal communication), teachers are considered to give the most balanced and objective information on children. Teachers have respect and credibility as informed and educated respondents. Children and their parents are said to give biased and subjective opinions, being reluctant to portray themselves or their family in a negative light in order to avoid stigma. Parents in this study are thought to be pre-occupied with sustaining the family's economic livelihood and consequently spend comparatively little time with their children who attend daytime school. Parents who are

stressed or overwhelmed themselves may overlook the problems of their children, whereas teachers are familiar with their pupils and under less stress. It is important to understand discrepancy between informants. In this study teacher-self interrater correlations for mental health difficulties are strong (p=0.001) but teacher-ratings were much worse than self-ratings.

d. Limitations and recommendations of study

Several limitations of the current study need addressing. Firstly, the nature of the sample is restricted in several ways. Replicating this study on a larger scale would add weight to findings as would a follow-up study to verify results. Adopting school registers as a sampling frame has the effect of excluding children who do not attend school who may be at additional risk. Using school registers may have also had the effect of introducing an element of gender bias because fewer girls than boys have the opportunity to attend school. It would be interesting to compare this sample of school children with children not enrolled in education. Similarly, a control group of local Pakistani children could be usefully compared to this sample of Afghan refugee children. Another bias could be related to the missing SDQs predominantly from the 'affluent' school where parents were unavailable to complete questionnaires.

There are some methodological issues relating to the way in which data were collected that need attention. Conducting interviews in a school setting introduces an element of bias into the study. Although research assistants were not attached to the school and interviews were conducted in private rooms, children's narratives are likely to have been inhibited by their expectations of 'correct' responses. In the Afghan context, data quality is likely to be affected by the private nature of grief (Wardak 1993:352), reluctance to discuss family problems with strangers, a strict gender divide (boys and girls were interviewed by female field assistants), and norms of adult authoritarianism over younger generations.

This study did not take into account other possible mediating factors that are likely to have an impact on the child, such as parental mental health, and did not include an independent measure of exposure to trauma and related loss. Although a purposive sample of children orphaned from one or more close relatives was selected by teachers, these children attended a private fee-paying school, and it is not clear to what extent this was a sample of children exposed to trauma or a sample of wealthy children who had the benefit of attending a private school. This study did not include standardised psychiatric interviews to verify results.

Is the SDQ a useful methodological tool for anthropologists? This study employed the SDQ was used to generate statistical information about the mental health strengths and weaknesses of Afghan refugee children. Qualitative information about how children view their lives in Peshawar was also collected in order to give context to psychological data. These two methodological approaches support each other's findings, while each also adds indispensably to the study. A validated screening instrument is useful for anthropologists to identify the scale of mental health problems and to draw comparisons between children's responses to displacement adversity cross-culturally, whereas anthropologically-informed research recognises cross-cultural variability, helping us to understand local perceptions of psychological distress, and how it is mediated through family and community networks of support. Anthropology reminds us to constantly question the cross-cultural robustness of psychological techniques devised in the West, look for indigenously constructed meanings of suffering, and also to take into account children's own views about their well-being.

It is important to know more about the consequences of war trauma and displacement on the mental health of children, but it is perhaps more important to understand how children understand and in particular cope with their experiences. Developing a consensus on a battery of research techniques to be used with refugee populations is a critical step in promoting further understanding of the impact displacement related adversity. This study has demonstrated some of the merits of both psychological and anthropological methodologies, and maintains that a multi-disciplinary approach is the only way to fully understand psychological distress, children's interpretations of their experiences and the factors that contribute to their resilience cross-culturally.

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Appendices

1.1. P4-16, SDQ and impact supplement for the parents of 4 to 16 year olds

Strengths and Difficulties Questionnaire P4-16

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of the child's behaviour over the last six months.

Child's Name ..... Male/Female

Date of Birth .....

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	☐	☐	☐
Restless, overactive, cannot stay still for long	☐	☐	☐
Often complains of headaches, stomach-aches or sickness	☐	☐	☐
Shares readily with other children (treats, toys, pencils etc.)	☐	☐	☐
Often has temper tantrums or hot tempers	☐	☐	☐
Rather solitary, tends to play alone	☐	☐	☐
Generally obedient, usually does what adults request	☐	☐	☐
Many worries, often seems worried	☐	☐	☐
Helpful if someone is hurt, upset or feeling ill	☐	☐	☐
Constantly fidgeting or squirming	☐	☐	☐
Has at least one good friend	☐	☐	☐
Often fights with other children or bullies them	☐	☐	☐
Often unhappy, down-hearted or tearful	☐	☐	☐
Generally liked by other children	☐	☐	☐
Easily distracted, concentration wanders	☐	☐	☐
Nervous or clingy in new situations, easily loses confidence	☐	☐	☐
Kind to younger children	☐	☐	☐
Often lies or cheats	☐	☐	☐
Picked on or bullied by other children	☐	☐	☐
Often volunteers to help others (parents, teachers, other children)	☐	☐	☐
Thinks things out before acting	☐	☐	☐
Steals from home, school or elsewhere	☐	☐	☐
Gets on better with adults than with other children	☐	☐	☐
Many fears, easily scared	☐	☐	☐
Sees tasks through to the end, good attention span	☐	☐	☐

Do you have any other comments or concerns?

Please turn over - there are a few more questions on the other side

Overall, do you think that your child has difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people?

No	Yes - minor difficulties	Yes - definite difficulties	Yes - severe difficulties
☐	☐	☐	☐

If you have answered "Yes", please answer the following questions about these difficulties:

- **How long have these difficulties been present?**

Less than a month	1-5 months	6-12 months	Over a year
☐	☐	☐	☐

- **Do the difficulties upset or distress your child?**

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

- **Do the difficulties interfere with your child's everyday life in the following areas?**

	Not at all	Only a little	Quite a lot	A great deal
HOME LIFE	☐	☐	☐	☐
FRIENDSHIPS	☐	☐	☐	☐
CLASSROOM LEARNING	☐	☐	☐	☐
LEISURE ACTIVITIES	☐	☐	☐	☐

- **Do the difficulties put a burden on you or the family as a whole?**

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

Signature ..... Date .....

Mother/Father/Other (please specify:)

Thank you very much for your help

T4-16, SDQ and impact supplement for teachers of 4 to 16 year olds

Strengths and Difficulties Questionnaire T4-16

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of the child's behaviour over the last six months or this school year.

Child's Name ..... Male/Female

Date of Birth .....

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	☐	☐	☐
Restless, overactive, cannot stay still for long	☐	☐	☐
Often complains of headaches, stomach-aches or sickness	☐	☐	☐
Shares readily with other children (treats, toys, pencils etc.)	☐	☐	☐
Often has temper tantrums or hot tempers	☐	☐	☐
Rather solitary, tends to play alone	☐	☐	☐
Generally obedient, usually does what adults request	☐	☐	☐
Many worries, often seems worried	☐	☐	☐
Helpful if someone is hurt, upset or feeling ill	☐	☐	☐
Constantly fidgeting or squirming	☐	☐	☐
Has at least one good friend	☐	☐	☐
Often fights with other children or bullies them	☐	☐	☐
Often unhappy, down-hearted or tearful	☐	☐	☐
Generally liked by other children	☐	☐	☐
Easily distracted, concentration wanders	☐	☐	☐
Nervous or clingy in new situations, easily loses confidence	☐	☐	☐
Kind to younger children	☐	☐	☐
Often lies or cheats	☐	☐	☐
Picked on or bullied by other children	☐	☐	☐
Often volunteers to help others (parents, teachers, other children)	☐	☐	☐
Thinks things out before acting	☐	☐	☐
Steals from home, school or elsewhere	☐	☐	☐
Gets on better with adults than with other children	☐	☐	☐
Many fears, easily scared	☐	☐	☐
Sees tasks through to the end, good attention span	☐	☐	☐

Do you have any other comments or concerns?

Please turn over - there are a few more questions on the other side

Overall, do you think that this child has difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people?

No	Yes - minor difficulties	Yes - definite difficulties	Yes - severe difficulties
☐	☐	☐	☐

If you have answered "Yes", please answer the following questions about these difficulties:

- How long have these difficulties been present?

Less than a month	1-5 months	6-12 months	Over a year
☐	☐	☐	☐

- Do the difficulties upset or distress the child?

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

- Do the difficulties interfere with the child's everyday life in the following areas?

	Not at all	Only a little	Quite a lot	A great deal
PEER RELATIONSHIPS	☐	☐	☐	☐
CLASSROOM LEARNING	☐	☐	☐	☐

- Do the difficulties put a burden on you or the class as a whole?

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

Signature ..... Date .....

Class Teacher/Form Tutor/Head of Year/Other (please specify:)

Thank you very much for your help

S11-16, SDQ and impact supplement for self-completion by 11 to 16 year olds

Strengths and Difficulties Questionnaire S[11-16]

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of how things have been for you over the last six months.

Your Name ..... Male/Female

Date of Birth .....

	Not True	Somewhat True	Certainly True
I try to be nice to other people. I care about their feelings	☐	☐	☐
I am restless, I cannot stay still for long	☐	☐	☐
I get a lot of headaches, stomach-aches or sickness	☐	☐	☐
I usually share with others (food, games, pens etc.)	☐	☐	☐
I get very angry and often lose my temper	☐	☐	☐
I am usually on my own. I generally play alone or keep to myself	☐	☐	☐
I usually do as I am told	☐	☐	☐
I worry a lot	☐	☐	☐
I am helpful if someone is hurt, upset or feeling ill	☐	☐	☐
I am constantly fidgeting or squirming	☐	☐	☐
I have one good friend or more	☐	☐	☐
I fight a lot. I can make other people do what I want	☐	☐	☐
I am often unhappy, down-hearted or tearful	☐	☐	☐
Other people my age generally like me	☐	☐	☐
I am easily distracted, I find it difficult to concentrate	☐	☐	☐
I am nervous in new situations. I easily lose confidence	☐	☐	☐
I am kind to younger children	☐	☐	☐
I am often accused of lying or cheating	☐	☐	☐
Other children or young people pick on me or bully me	☐	☐	☐
I often volunteer to help others (parents, teachers, children)	☐	☐	☐
I think before I do things	☐	☐	☐
I take things that are not mine from home, school or elsewhere	☐	☐	☐
I get on better with adults than with people my own age	☐	☐	☐
I have many fears, I am easily scared	☐	☐	☐
I finish the work I'm doing. My attention is good	☐	☐	☐

Do you have any other comments or concerns?

Please turn over - there are a few more questions on the other side

Overall, do you think that you have difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people?

No	Yes - minor difficulties	Yes - definite difficulties	Yes - severe difficulties
☐	☐	☐	☐

If you have answered "Yes", please answer the following questions about these difficulties:

- How long have these difficulties been present?

Less than a month	1-5 months	6-12 months	Over a year
☐	☐	☐	☐

- Do the difficulties upset or distress you?

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

- Do the difficulties interfere with your everyday life in the following areas?

	Not at all	Only a little	Quite a lot	A great deal
HOME LIFE	☐	☐	☐	☐
FRIENDSHIPS	☐	☐	☐	☐
CLASSROOM LEARNING	☐	☐	☐	☐
LEISURE ACTIVITIES	☐	☐	☐	☐

- Do the difficulties make it harder for those around you (family, friends, teachers, etc.)?

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

Your Signature .....

Today's Date .....

Thank you very much for your help

2.1. Child & Family History Questionnaire

RESPONDENT NUMBER SEX SCHOOL
INTERVIEWER NAME DATE

I would like to talk to you about your home, family and day-to-day life.

Q1. Where were you born? (CIRCLE Afghanistan/Pakistan)

Q2. How many years have you lived in Peshawar for?_____

Q3. How old are you?_____
EXACT AGE IN YEARS

Q4. Which language do you speak at home?
(if more than one, ask which language is used most?)
AWAIT REPLY, CIRCLE ONE ANSWER ONLY
1. Pashto, 2. Dari, 3. Punjabi, 4. Urdu, 5. Other (RECORD_____)

Q5. Which other languages can you speak?
CIRCLE ANSWERS
Pashto, 2. Dari, 3. Punjabi, 4. Urdu, 5. Other (RECORD_____)

Q6. Does your home have running water? (CIRCLE Yes/no)

Q7. Do you have these items in working order in your home?
READ EACH ITEM AND CIRCLE (multiple responses OK)
Radio_____ 2. TV_____ 3. Telephone_____ 4. Mobile phone_____
VCR_____ 6. Satellite dish_____

Q8. Who lives in your home?
CIRCLE ALL ANSWERS
1. Father (Yes/no) 2. Mother (Yes/no)
3. Brothers (number_____) 4. Sisters (number_____)
5. Grandparents (number_____) 6. Uncles and aunts (number_____)
7. Cousins (number_____) 8. Other (_____)
RECORD total number of residents, including child_____

Q9. How many more relatives do you have?
RECORD EXACT NUMBER (those the child knows by name)_____
1. Chachazad (number_____) 2. Poupizad (number_____)
3.Khalazad (number_____) 4. Mamouzad (number____)

Q10. Do you have any family members living in Afghanistan?
1. Yes 2. No 3. Don't know/no answer

Q11. How many friends do you have?
RECORD EXACT NUMBER (other than family)_____

Q12. Do you work? (CIRCLE Yes/no)

Q13. When you graduate from school, what do you want to do?_____

Q14. SHOW MAP to see if they recognise countries
Afghanistan Pakistan Iran Afghanistan

2.2. Open-ended interview: example questions

RESPONDENT NUMBER SEX SCHOOL

INTERVIEWER NAME DATE

I would like to ask you some questions about you and your family.

Q1. How old are you?

Q2. What did you do yesterday?

Q3. What did you do when you woke up yesterday?

Q4. What did you do after that?

Q5. Who was with you?

Q6. Do you like living in Peshawar?

Q7. Why do you like/dislike living in Peshawar?

Q8. What don't you like about living in Peshawar?

Q9. When do you feel happy?

Q10. When do you feel sad?

Q11. When do you feel scared?

Q12. When you feel scared, is there anybody to help you?

Q13. Who else helps you?

Q14. How do you help your family?

Q15. Do you help your friends?

Q16. Do you listen to the radio?

Q17. Can you tell me who the president of Pakistan is?

Q18. Can you tell me who the president of Afghanistan is?

Q19. How has war in Afghanistan affected your family?

Q20. What kind of impact has war had on you?

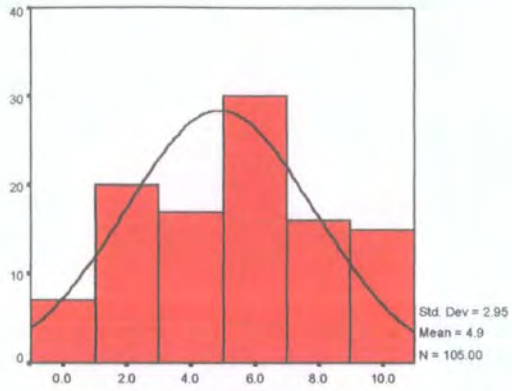
Q21. Why do you feel upset?

Q22. What do you think about life in Afghanistan and Pakistan? Which one is better?

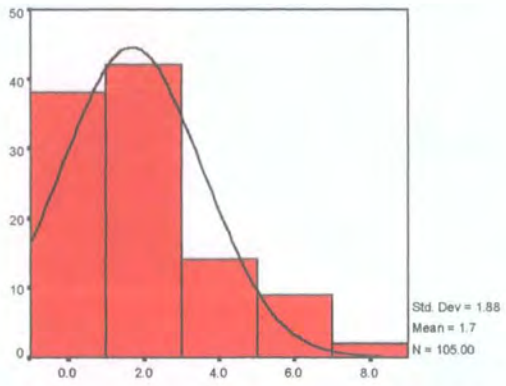
Q23. What do you want to be in the future?

Q24. What will help you achieve your ambitions?

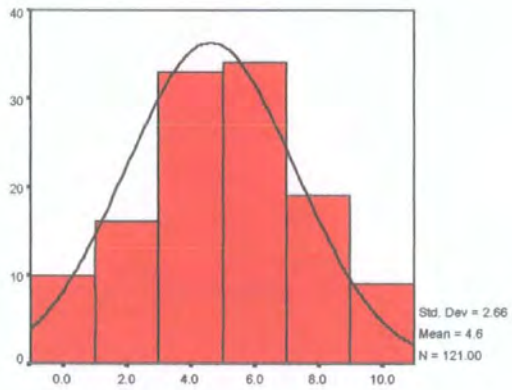
3.1. Histograms showing distribution of subscale scores



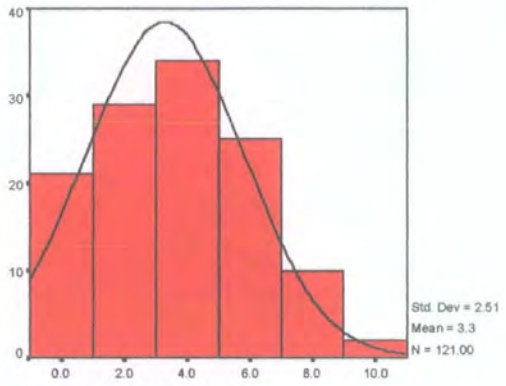
Emotional score as rated by parent



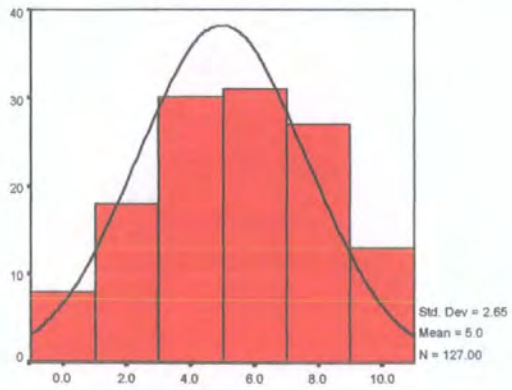
Conduct score as rated by parent



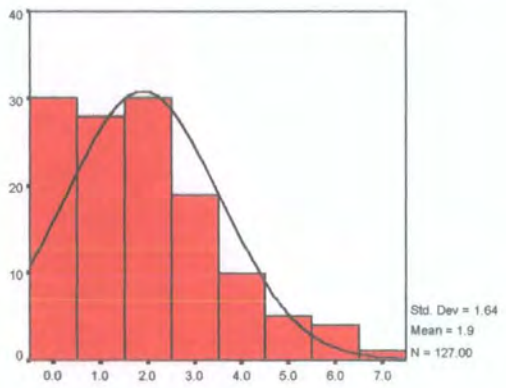
Emotional score as rated by teacher



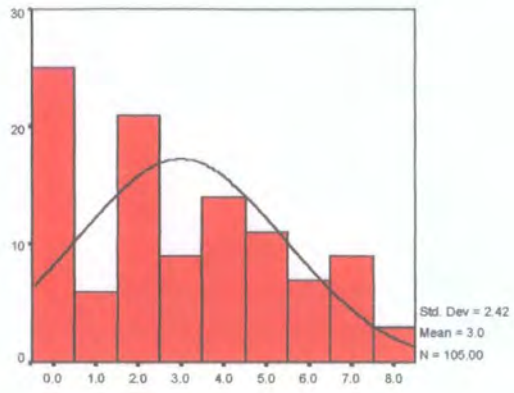
Conduct score as rated by teacher



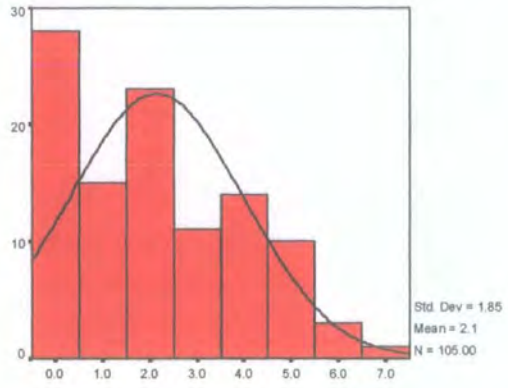
Emotional score as rated by self



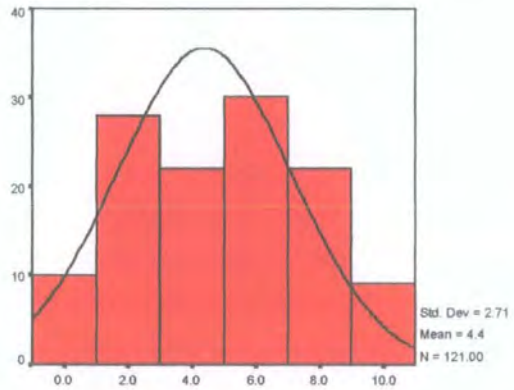
Conduct score as rated by self



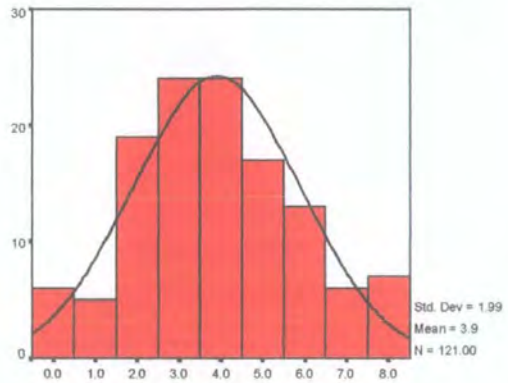
Hyperactivity score as rated by parent



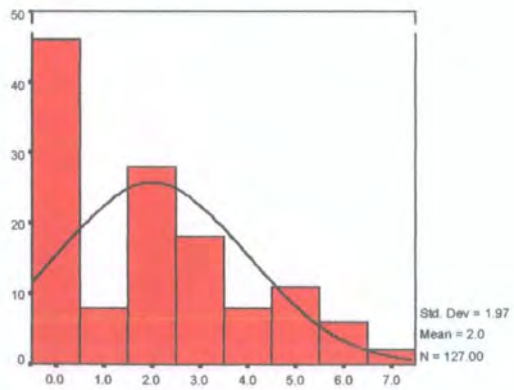
Peer problems score as rated by parent



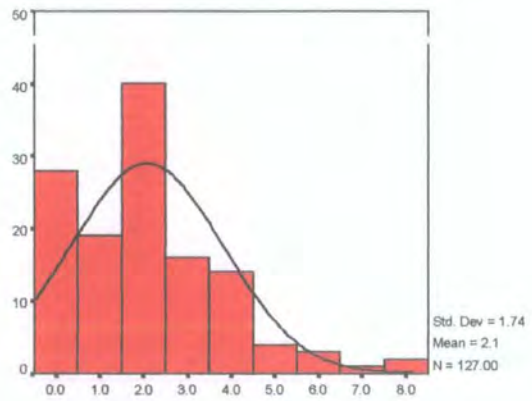
Hyperactivity score as rated by teacher



Peer problems score as rated by teacher



Hyperactivity score as rated by self



Peer problems score as rated by self

3.2. Subscale scores as rated by different informants

			Afghan sample	British norm[1]
Emotional symptoms	Parent	Mean	4.91	1.9
		Median	5.00	n/a
		N	105	4443
		SD	2.95	2.0
		Rating	Abnormal	Normal
	Teacher	Mean	4.63	1.3
		Median	5.00	n/a
		N	121	3407
		SD	2.66	1.9
		Rating	Borderline	Normal
	Self	Mean	4.98	2.8
		Median	5.00	n/a
		N	127	4228
		SD	2.65	2.1
		Rating	Normal	Normal
Conduct problems	Parent	Mean	1.69	1.5
		Median	1.00	n/a
		N	105	4443
		SD	1.88	1.7
		Rating	Normal	Normal
	Teacher	Mean	3.30	0.9
		Median	3.00	n/a
		N	121	3407
		SD	2.51	1.7
		Rating	Borderline	Normal
	Self	Mean	1.90	2.2
		Median	2.00	n/a
		N	127	4228
		SD	1.97	1.7
		Rating	Normal	Normal

Hyperactivity/ inattention problems	Parent	Mean Median N SD Rating	3.00 3.00 105 2.42 Normal	3.2 n/a 4443 2.6 Normal
	Teacher	Mean Median N SD Rating	4.39 5.00 121 2.71 Normal	2.6 n/a 3407 2.7 Normal
	Self	Mean Median N SD Rating	2.01 2.00 127 1.97 Normal	3.8 n/a 4228 2.2 Normal
Peer relationship problems	Parent	Mean Median N SD Rating	2.14 2.00 105 1.85 Normal	1.5 n/a 4443 1.7 Normal
	Teacher	Mean Median N SD Rating	3.90 4.00 121 1.99 Borderline	1.4 n/a 3407 1.8 Normal
	Self	Mean Median N SD Rating	2.08 2.00 127 1.74 Normal	1.5 n/a 4228 1.4 Normal

[1] Available at http://www.sdqinfo.com, data for 11-15 year olds

3.3. Strengths and difficulties scores by school sample (percentages)

	Informant	**Rating**	**School**				**Total**
			Very poor	Poor	Affluent	Orphaned	
TDS	Parent	Normal	58	71	67	47	62
		Borderline	18	11	22	26	18
		Abnormal	24	17	11	26	20
	Teacher	Normal	17	37	38	6	28
		Borderline	21	20	15	29	20
		Abnormal	62	43	48	65	52
	Self	Normal	81	80	78	75	79
		Borderline	13	11	15	25	15
		Abnormal	6	9	8	0	6
Prosocial score	Parent	Normal	100	91	89	84	92
		Borderline	0	0	0	5	1
		Abnormal	0	9	11	11	7
	Teacher	Normal	79	77	73	71	75
		Borderline	10	14	20	18	16
		Abnormal	10	9	8	12	9
	Self	Normal	100	100	100	100	100
		Borderline	0	0	0	0	0
		Abnormal	0	0	0	0	0

4.1. Stepwise logistic regressions to predict abnormal TDS ratings from displacement and family/peer relations variables

Outcome[1]	**N**	**Predictors**[2]		**B**	**OR**	**95% CI**		**Sig.**
						Lower	Upper	
*p*TDS	89	Yrs. in Peshawar		0.24	1.27	1.04	1.55	0.009
		Father living in household	Yes	Baseline				
			No	1.79	6.01	1.81	19.89	0.002
*t*TDS	89	Age		-0.63	0.54	0.36	0.79	0.001
		Father living in household	Yes	Baseline				
			No	1.78	5.94	1.70	20.67	0.002
*s*TDS	89	Extended family size		0.06	1.07	1.02	1.12	0.007

[1] TDS scores dichotomised as normal & borderline vs. abnormal

[2] Predictor variables were school, gender, age, place of birth, years in Peshawar, household size, father living in household, extended family size and number of friends. Only significant variables are shown.